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As the Independent Chair of the Greenwich Safeguarding Children Board (GSCB) I am pleased to present the Annual Report for the period April 2018 to March 2019. This is my last Annual report as the Independent Chair as I move to a new role as Independent Scrutineer under the new Multi-Agency Safeguarding Arrangements. There will continue to be a requirement to publish an Annual Report and I will continue to contribute in this new role.

Local Safeguarding Children Boards (LSCBs) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they intervene, they make a positive difference in children’s lives. The GSCB has an important role in co-ordinating and ensuring the effectiveness of what is done by each person involved in protecting children and carries statutory responsibilities for safeguarding children in Royal Greenwich. It is made up of senior managers within organisations in Royal Greenwich who hold responsibility for safeguarding children in their agencies, such as children’s social care, police, health, schools and other services including voluntary bodies. The GSCB monitors how they work together to provide services for children and ensure they are protected.

Last year saw the development of new Multi-Agency Safeguarding Arrangements which have replaced LSCBs. The Partnership Plan for Greenwich was published at the end of March 2019 and the new arrangements began in June 2019. There has been careful planning and consultation over the last year to develop this plan, which will reduce duplication and join up with other partnership groups and across boundaries, with a real focus on making a difference to front line practice to safeguard children and build on what works well.

A new partnership has been created between the Royal Borough of Greenwich, the Southeast Basic Command Unit of the Metropolitan Police and NHS Greenwich Clinical Commissioning Group. This new partnership is firmly built on strong collaborative working relationships and shared aspirations for children and young people in Greenwich. The Partnership is clear that children are at the heart of everything we do and is focussed on promoting, encouraging and developing resilience. They are committed to listening to and involving children, young people and families and to building collaborative partnerships, learning from each other and promoting challenging and supportive conversations that focus on the experience of the child. The partnership is clear that it needs to be outcome focused, ensuring that services make a difference to the lives of children, young people and their families in Greenwich.

The challenge over the next year is ensuring that replacing the GSCB with the new arrangements is done carefully and the transition is effectively monitored and reviewed. This will be challenging for all agencies, with considerable change within their own organisations. We will need to ensure the focus and delivery of services to vulnerable children, young people and families is not adversely affected.

I would like to thank the Board staff, for their continued support in the smooth functioning and promotion of the GSCB. I would also like to thank members of the Board, from across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safer in Greenwich.

Nicky Pace - GSCB Independent Chair
How effective is the GSCB in improving the safety of children in Royal Greenwich?

Nicky Pace, GSCB Independent Chair

This Annual report highlights progress and improvements across the partnership over the past year and evidences both effective joint working and single agency focus on safeguarding and promoting the welfare of our children and young people in Royal Greenwich. The Annual report covers the work of all the sub-groups of the Board and the activity over the last year and evidences the concerted and proactive actions taken to address areas identified in audits or data where practice may not be effective. The report comments on the key areas of statutory responsibility of the Board: the work of the CDOP (Child Death Overview Panel), Multi-Agency Training and the impact on front line practice, Private Fostering and allegations against professionals.

The Board has also had to focus this year on developing new arrangements as required by the Children and Social Work Act 2017 and Working Together 2018. This has involved a review of all the sub groups of the current board, functions, membership and funding. We were lucky to be accepted as one of the Early Adopters of the new arrangements alongside Bexley and Lewisham. This enabled us to look at how we might work more effectively across borough boundaries, avoiding duplication but also sharing learning. It has also helped us consider and develop the new independent scrutineer role required in the new partnership arrangements. We published our Partnership plan outlining our new arrangements in March. This can be found on our website – click here

Unfortunately the Board has been affected this last year by staffing issues. The team that supports the Board is small so any loss or absence of staff has a major impact on capacity and continuity. This has impacted on the ability of the Board to undertake some of its planned work. As part of the planning of the new arrangements we have re-organised the team and this will be implemented in September 2019.

The Board regularly reviews the performance of professionals working with children through its programme of multi-agency audits and by examining the results of single agency audit work. The development of multi-agency auditing across Greenwich continues to be a strength and highlights the commitment of partners to understand the effectiveness of practice and to address any shortfalls. The main work of the audit group this year was a Deep Dive audit of children’s mental health. The intention was to explore provision for children with low level or emerging needs. The audit work group also developed a neglect survey to explore the understanding of Greenwich’s workforce when it comes to thresholds around intervention for neglect and the complexity of making judgements. The Board is clear we identify an issue, take action, audit the effectiveness of our actions, identify any further areas for development and then re-audit to ensure the actions we have taken are embedded and have made the difference we expect. More details of this work can be found in the main body of the report.

The Board revised its processes for undertaking section 11 audits in 2016-2017 and has repeated this process again this year but in a more limited focus due to capacity. This year the Section 11 audit focussed on 2 sectors of the workforce; Sports and Leisure, and schools. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The S11 self-assessment questionnaire designed by the GSCB is one of the key tools being used by the Board to assess and monitor whether staff in all
agencies are able to properly safeguard children. It has given the board the opportunity to understand how well frontline staff understand safeguarding across the partnership.

The GSCB has published 1 serious case review this year relating to the sad death of a child in 2016. There is a further serious case review which has been completed and action implemented, however remains unpublished due to parallel processes. A new Serious Case Review has also been undertaken in 2018-2019. This relates to a family with multiple complex needs and a long history of service involvement. This review is now ready for publication but is being held up by parallel processes within the judicial system. However, early learning from these cases has resulted in actions being undertaken prior to publication of the reports and has helped shape the Board’s priorities for the coming year.

**Priorities 2018-2019**

The Board is required to report on progress against the priorities set for the previous year, look forward and plan any changes to the safeguarding priorities for the local area for the next year. We also take into account national priorities and local needs and any issues arising from SCRs and multi-agency audits. When deciding our priorities, we acknowledge that our core business of safeguarding children is on-going, including identifying, assessing and providing services and help to those children who need protection. In deciding the Board’s improvement priorities, we consider how well we have delivered our priorities from the previous year and if further work is needed. We recognise that with the changes being made to the partnership arrangements that we should focus on fewer key areas for improvement. The priorities focused on safeguarding and promoting the rights of children in relation to the following groups:

**Tackling the risks to adolescents, particularly those associated with exploitation (including harmful sexual behaviour and online abuse) violence and neglect.**

Following the Joint Targeted Area Inspection (JTAI) in February 2018, the GSCB has closely monitored the Action Plan following the inspection. There has been considerable awareness raising about exploitation across a number of professional groups, schools and early help settings. The GSCB Annual conference held in October 2018 was “Safeguarding Children from Gangs: What Works?”. The conference included presentations from national and local experts and workshops which were well attended and received positive feedback. Children’s Services, the Greenwich Young People’s Council and Charlton Athletic Community Trust held an Anti-Knife Crime Summit for young people in in February 2019 to which up to 6 young people from each school and alternative provision were invited. There has been multi-agency development and dissemination of a “Contextual Risk Early Identification Tool” designed to support practitioners in universal and targeted services and in particular schools to help identify and respond to this cohort of young people. The GSCB Neglect strategy has also been relaunched and covers adolescent neglect.

The sub-groups dealing with these areas of risk have all been combined into one panel (GRASP), recognising that vulnerability and risk to young people covers a number of different aspects including going missing and wider exploitation as well as CSE and county lines. Further work is underway through a task and finish group to develop practice guidance for adolescent risk and work with head teachers to reduce fixed term exclusions. The audit group also plan a repeat Deep Dive audit of adolescents at risk to identify if there had been changes since the JTAI.

Further details on this can be found in the section – Safeguarding children from exploitation.

Supporting children to maintain positive mental health, with a particular focus on
deliberate self-harm and suicide. The Deep Dive children’s mental health audit undertaken this year positively engaged with young people and gained a wealth of information which influenced the development of the action plan and changes in services alongside the information from file audit and discussion with parents and practitioners. A key finding was that young people need to be able to access support when it is needed and have a choice about who to talk to – this means that as many children’s practitioners as possible need to understand how to respond. Over 2019-2020 we will be improving access for schools to Youth Mental Health First Aid training in response to the findings of the audit, which demonstrated that school is the most likely place for a young person to look for support. As a result we have also commissioned two new training courses for professional staff ‘Children’s Mental Health; Understanding the Issues and Promoting Positive Emotional Well-being’ and ‘Understanding Adolescent Mental Health: Implications for Practice & Improving Emotional Well-being’.

Recognising vulnerability and providing the right support to protect and nurture during pregnancy and early infancy.

Findings from the ‘Safeguarding Babies’ audit were shared across the health economy and we requested the development of action plans from health providers to evidence that these findings inform practice as part of ongoing quality improvement processes. In this period the Board worked closely with Lewisham and Greenwich NHS Trust Midwifery department to review their ‘maternity safeguarding’ pathway and ensure it links well with Multi-Agency Safeguarding Hub (MASH) with a refining of the threshold required for referral. The aim was to efficiently and accurately identify vulnerable pregnant women at risk. Quality visits were also carried out to assess new practice of incorporating checking baby sleeping arrangements by health visitors. The National Society for the Prevention of Cruelty to Children (NSPCC) ‘Handle with Care’ booklets were disseminated widely across GP practices, Children’s Centres, Community Services and Queen Elizabeth Hospital.

The GSCB have developed two new courses called ‘Assessing and Supporting Parenting Capacity During Pregnancy’ and ‘Keeping Babies and Young Children Safe: Understanding Child Development to Build Strong Foundations’ to help staff understand these issues.

Safe sleeping advice for infants must continue to be promoted to new parents as evidence from our CDOP continues to find co-sleeping as a key risk factor in cases of sudden unexpected/ unexplained deaths of infants. Consequently we will undertake a re-audit of Safeguarding Babies next year.


As we move into the new partnership arrangement we have agreed to maintain the same priority areas and over the next year develop across the partnership our new priorities and areas of focus.

The full report gives a detailed picture of how all partner agencies have worked together to keep children and young people safer. The report is structured as follows:

- Work group reports provide more detail on how the GSCB Work Groups delivered against the agreed Business Plan for 2018-2019.
- Reports on the statutory functions of the GSCB including private fostering, allegations against professionals, missing children and those at risk of child sexual exploitation.
- Individual statutory and voluntary agency reports describe how they contributed to safeguarding children in the borough – successes, challenges and plans.
- The Appendices set out details of the attendance of the Board Executive, financial contributions, multi-agency training attendance, current GSCB structure and membership.
GSCB Strategic Priorities 2019 - 2020

In addition to the statutory requirements set out in Working Together 2018, the Greenwich Safeguarding Children Board (GSCB) set local strategic priorities each year, which were informed by:

- Feed-back received from GSCB members during the Board Development session.
- GSCB quality assurance activity and analysis of performance data.
- Views of front-line practitioners who responded to multi-agency survey.
- Learning from SCRs, both local and national.
- Feed-back provided by children, young people, parents and members of the community.
- Views of children and young people gathered via the SHEU survey, audits and questionnaires.

Safeguarding children and young people is the overarching priority for all services working together in Greenwich. Hearing the voice of children and young people to inform the partners of issues and to hear how well we are safeguarding them is a focus for the whole partnership. The new Greenwich Safeguarding Children Partnership continues to bring together senior leaders to promote partnership working and co-operation, identify and promote a learning and development culture, whilst overseeing efforts to improve safeguarding services for children through active challenge and scrutiny.

For 2019-2020 it has been decided that the new safeguarding partnership will maintain the same priorities from 2018-2019, as there is further work to do to ensure that the improvements identified are embedded in these areas. These priorities are also in line with the Children and Young People’s Plan 2017-2020 and will be reviewed in line with this for 2020-2021.

GSCB Strategic priorities for 2018-2020

1. Tackling the risks to adolescents, particularly those associated with exploitation (including harmful sexual behaviour and online abuse) violence and neglect.

2. Supporting children to maintain positive mental health, with a particular focus on deliberate self-harm and suicide.

3. Recognising vulnerability and providing the right support to protect and nurture during pregnancy and early infancy.
GSCB Underlying Principles

The GSCB was a **child centred partnership** that was **independent** from all organisations. It provided **system wide leadership** and had responsibility for the **scrutiny and challenge** of safeguarding practices throughout agencies in the Royal Borough of Greenwich. This remains unchanged in the new partnership.

*The interests of children and young people and their experience of services are central to the work and strategic decisions made by the Partnership.*

Throughout the work of the Board, the emphasis has been on **facilitating continuous learning** with the aim of constantly **improving practice** so that children, young people and families are receiving effective services and support as early as possible.

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**Safeguarding and Promoting the Welfare of Children is defined as:**

- Protecting children from maltreatment;
- Preventing impairment of children’s health or development;
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best outcomes.

*Working Together to Safeguard Children 2018*
<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living in Royal Greenwich</td>
<td>69,800</td>
</tr>
<tr>
<td>Children receiving early help at the year end</td>
<td>497</td>
</tr>
<tr>
<td>Children's Social Care referrals</td>
<td>3343</td>
</tr>
<tr>
<td>Percentage of re-referral to Children's Social Care</td>
<td>15%</td>
</tr>
<tr>
<td>Percentage of MARAC cases where a child is known to be involved</td>
<td>58%</td>
</tr>
<tr>
<td>Children subject to a child protection plan during the year</td>
<td>499</td>
</tr>
<tr>
<td>Children stepped down from a CP plan to CIN or TAC</td>
<td>193</td>
</tr>
<tr>
<td>Children who received Early Help were not later referred to Children's Social Care or Youth Offending</td>
<td>84%</td>
</tr>
<tr>
<td>Children had a new CP Plan made for a second or subsequent time</td>
<td>45</td>
</tr>
<tr>
<td>Review Child Protection Conferences were held within timescale</td>
<td>99%</td>
</tr>
<tr>
<td>Serious Case Review initiated by the GSCB</td>
<td>1</td>
</tr>
<tr>
<td>Children missing from home or care for more than 24 hours during the year</td>
<td>160</td>
</tr>
<tr>
<td>Looked After Children at end of March 2019</td>
<td>480</td>
</tr>
<tr>
<td>Practitioners attended a GSCB multi-agency training event in 2018/19</td>
<td>1821</td>
</tr>
<tr>
<td>Young people aged 10-17 received custodial sentences</td>
<td>11</td>
</tr>
</tbody>
</table>
GSCB Work Groups
Monitoring and Challenge

MAC Group Chair: Nicky Pace, GSCB Independent Chair

The Monitoring and Challenge (MAC) group strengthens the process of monitoring, scrutinising and evaluating safeguarding practice by all GSCB partner agencies both individually and collectively and holds agencies to account on how effectively they have safeguarded and promoted the welfare of children. The MAC focuses on the quality assurance of multi-agency arrangements, practice and service delivery. It identifies areas of development and barriers to learning, improvement and change.

The MAC is responsible to the GSCB for establishing, co-ordinating, implementing and monitoring quality assurance activity and performance issues on a multi-agency basis in respect of safeguarding children and young people. It monitors the GSCB Business Plan and dataset. The MAC also reviews the multi-agency training programme to ensure multi-agency safeguarding training meets the local workforce needs and that the quality of this training is monitored and evaluated. Its focus is also to identify priorities for multi-agency child protection training in the local area and feed these into the local workforce strategy.

Over the last year the MAC has received the following reports:

- Regular updates on the Children and Social Work Act and Working Together guidance, the Early Adopter bid and progress towards the implementation of the new Multi-Agency Safeguarding Arrangements.
- There have been several annual reports received such as the CDOP, Independent Reviewing Officers (IRO) and the report on Child Protection from the CP Chairs. The MAC has also scrutinised reports on the support for disabled children, Anti-bullying, CAMHS and integrated work on gangs as well as learning from particular cases, the CCG assurance report, hate crime as a safeguarding issue and harmful sexual behaviour updates. The MAC has also signed off a number of factsheets for onward circulation to professionals working in safeguarding concerning Professional Curiosity and procedural response to child sexual abuse.
- The MAC receives regular feedback from Multi-Agency Audits – it has received the outcomes from the Neglect threshold audit, the sexual health audit and Child Protection medica.
- On a routine basis the MAC receives the GSCB Dataset and reviews the Overarching Action Plan. The S11 audit is co-ordinated and agreed by this group, as well as monitoring actions and recommendations.

Section 11/ S 175 audits

Section 11 (4) of the Children Act 2004 requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Working Together to Safeguard Children 2015 states that one of the key functions of a Local Safeguarding Children Board is:

“monitoring and evaluating the effectiveness of what is done by the authority and their board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve”

One of the ways in which Greenwich Safeguarding Children Board (GSCB) ensure that this function is fulfilled is by undertaking an annual section 11 audit to provide partner
agencies with an opportunity to focus on their arrangements for safeguarding children and to identify any need for improvement. GSCB began using a new process for the section 11 audit. It also covers S175 of The Education Act 2002 and the DfE guidance Keeping Children Safe in Education (KCSE) and provides external validation for schools about the understanding of safeguarding by their staff.

This year the Section 11 audit focussed on 2 sectors of the workforce; Sports and Leisure, and schools. The limited focus was due to capacity issues in the Board during the last year.

What was the impact?

This was the first time the Board had engaged the wider network of sports clubs and leisure centres in the section 11 and for that reason there was some difficulty in achieving a strong response. This was particularly the case with small independent clubs and coaches as they were difficult to identify and there was no information on the size of each service. The exercise was more successful with Greenwich’s commissioned leisure services, via the engagement of their regional manager and national safeguarding lead, however the response rate was still fairly low and due to this it has not been possible to obtain a definitive picture of safeguarding performance and understanding within the borough overall. The responses that were received indicated that the vast majority are aware of safeguarding procedures, how to recognise and what to do in response to safeguarding concerns. There is a need for greater monitoring of safeguarding training compliance – including ensuring that this is updated at least every 3 years. Although there is still much work to be done, particularly with the smaller clubs dispersed throughout the borough, significant progress has been made this year in building relationships with a sector which the GSCB previously had very little contact with, and we look forward to working with both our large providers and RBG Communities and Environment to strengthen our understanding and confidence that children are able to safely participate in sports and other activities in Greenwich.

The schools Section 11 audit has demonstrated that GSCB have good reason to be confident in the safeguarding commitment and performance of the borough’s schools. Year on year there is an overall increase in the number and range of school staff responding to the survey, with 2,573 completing the survey across 94 schools in the 2018-19 survey. In Greenwich most of our schools are well engaged with the safeguarding partnership and are committed to continual learning and improvement to make children safer and their futures brighter. There is a high level of knowledge and confidence in relation to safeguarding and in most schools the staff feel well supported. Despite this the number of schools returning self-assessments and action plans following the survey remains low and further focus is needed to ensure that schools are using the information from the surveys purposefully. There are still a small number of schools who are not responding to the survey, or not returning a significant response. 29 schools (26%) returned under 10 responses to the survey with 13 schools (12%) returning no response. These schools will be targeted in our next round of S11 audits to understand why they have not undertaken the process.

What do we plan to do next?

The MAC will not continue into the new arrangements as currently stands but a new Development, Monitoring and challenge group is set up as part of the new Multi-agency safeguarding Arrangements.
Quality and Effectiveness of Arrangements and Practice

Audit Work Group Chair: Henrietta Quartano until November 2018 then Christine Robinson
Both Head of Service, Quality Improvement Service RBG Children’s Services

What did we do?
The Audit Group supports the GSCB in evaluating the effectiveness of all agencies in Royal Greenwich in relation to their work in safeguarding and promoting the well-being of children. The Audit Group carries out this function through leading on a range of audits in line with and reviewing single agency quality assurance activity. The audits are linked to the GSCB priorities and seek to answer probing questions about effective practice; challenging partners where required and seeking the views of parents, carers and children to better inform our understanding of a safeguarding issue. Audit activity needs to result in action to improve practice and the outcomes for children. The group presents its findings to the GSCB Executive and requests that each agency identifies improvement actions to incorporate into the overarching GSCB action plan. The group benefits from good multi-agency attendance and commitment to audits. The findings of all audits are circulated within services and to GSCB work groups and the Executive.

Work in line with GSCB Priorities
Tackling the risks to adolescents, particularly those associated with exploitation

- The audit work group developed a neglect survey to explore the understanding of Greenwich’s workforce when it comes to thresholds around intervention for neglect and the complexity of making judgements.
- In particular it aimed to reflect the need for professional curiosity and exploration when considering whether a child is experiencing neglect and subsequent decision-making, and to identify areas of strength and areas of inconsistency and instigate discussion and reflection.
- Most of the questions were not designed to elicit straight-forward responses but rather to encourage respondents to explore the complexity of scenarios and comment on what further information might be necessary in order to determine whether there are issues of child neglect and what form of intervention might be necessary.
- Reassuringly, 95% of respondents recognised neglect as a significant safeguarding issue in Greenwich, however there were a number of areas where further training and education was needed. There was some evidence of strong professional curiosity however many practitioners do not have a nuanced enough understanding or approach to neglect. Some responses were more parent-focussed than child-focussed, while others were overly critical. Professional understanding of the laws in relation to neglect is not always accurate or helpful. There is limited impact of formal written strategies for frontline workers. Anecdotal evidence indicates that the survey generated some interesting discussion within teams and that was in itself a learning exercise as it prompted respondents to reflect on their understanding and assumptions about child neglect.
- The audit group began to plan a repeat Deep Dive audit of adolescents at risk to identify if there had been changes since the JTAI inspection of this group in February 2018. This will be completed in 2019-2020.

Supporting children to maintain positive mental health

The main work of the audit group this year was a Deep Dive audit in relation to children’s mental health. A cohort of children were selected at random from all of those who were referred to but declined by CAMHS, and parental consent was obtained to explore the support offered to 8 children.

The intention was to explore provision for children with low level or emerging needs, and consultation with young people also enabled a discussion of the experiences of children accessing support at Tier 3.

The following agencies took part in this audit: Children’s Social Care, Early Help, the Youth Offending Service, Lewisham and Greenwich NHS Trust, Oxleas NHS Foundation Trust, Greenwich Clinical Commissioning Group and
MetroGAVS (who co-ordinated the response on behalf of the voluntary sector).

There were 4 strands to the deep dive; a multi-agency case file audit, feedback from parents, consultation with practitioners, and consultation with children and young people via questionnaire and focus groups. There was much consistency between the different strands of the audit – many of the same issues were raised by children, families and practitioners.

Key findings included:

Young people are discouraged from seeking support if they think they will have no choice in relation to what happens next. They want to be able to choose who they speak to, and for that person to listen and try to understand. They want to be clear on the application of confidentiality. School came through very strongly as a place to access mental health support and this seems to be where most impact can be made in relation to early intervention; however we also need to think about how support can be made accessible to children who are not attending school.

It is important for young people to be able to access support when it is needed and have a choice about who to talk to – this means that as many children’s practitioners as possible need to understand how to respond. Professionals need to be more adaptive to the ways in which children and young people communicate.

Greater awareness is needed of sources of support for emerging and low-level mental health needs, and this should include access to social opportunities, activities and peer support.

It should be the young person’s choice as to whether they share concerns with their parents, unless they are at risk. Stigma and misunderstanding are widespread, and some parents require support to understand and respond in supportive ways.

Young people had a number of suggestions for improving practice which have been included in the action plan.

**Recognising vulnerability and providing the right support to protect and nurture during pregnancy and early infancy**

Group members reviewed the Safeguarding Babies Action Plan developed from the audit carried out in 2017-2018 and concern was raised about the lack of work group and agency input to action planning. It was agreed work group chairs would be made responsible for providing actions for action plans. It was agreed that work group members would ensure that the GSCB are aware of ways in which their agencies are implementing the audit findings.

The Deep Dive mental health Audit positively engaged with young people and gained a wealth of information which influenced the development of the action plan and changes in services alongside the information from audit and discussion with parents.

As a result of findings from the neglect audit the professional curiosity fact sheet was devised and published on the website.

**What we plan to do next?**

Support the GSCP priorities for 2019-2020; the GSCP Audit Group will be completing the following audits:

- Deep dive audit of Adolescents at Risk
- A re-audit of Safeguarding Babies
Multi-Agency Training

Learning and Development Work Group Chair: Louise Mackender de Cari, Assistant Director Commissioning & Resources, RBG Children’s Services

What did we do?

Learning and development priorities for the year were identified through a needs assessment which included feedback from front line practitioners; training impact evaluations; Section 11 audit results; recommendations from local and national serious case reviews; key messages from national research; national guidance and policy and multi-agency audits. A comprehensive programme of multi-agency safeguarding training was designed and developed in line with the GSCB and Children and Young People Plan strategic priorities, Working Together to Safeguard Children, Ofsted thematic reviews and independent inquiries.

The multi-agency training programme was revised to meet emerging needs and to support the delivery of all the GSCB priorities. Additional courses and briefings added to the 2019-20 programme included:

- Allegations against Staff and Volunteers: understanding the LADO process
- Assessing and Supporting Parenting Capacity During Pregnancy
- Child Sexual Abuse: Demystifying the Paediatric Assessment & Aiding the Legal Process
- Children's Mental Health; Understanding the Issues and Promoting Positive Emotional Well-being
- Keeping Babies and Young Children Safe: Understanding Child Development to Build Strong Foundations
- Understanding Adolescent Mental Health: Implications for Practice & Improving Emotional Well-being
- Understanding Personality Disorders & Implications for Child Development and Parenting

These courses seek to bridge gaps identified via the Section 11 audit and feedback from partners, as well as to promote learning in relation to GSCB priorities. We have increased learning support on 2 of the 3 key priorities. In relation to risks to adolescents posed by exploitation we promote and signpost to the training offer by RBG Community Safety.

Workshops have also been delivered in relation to recently published local serious case reviews. The group has been considering other ways of embedding learning for those who don’t attend classroom training, such as disseminating factsheets, exercises and PowerPoint presentations for use in team meetings.

What was the impact?

Over the course of the year 1,821 practitioners and volunteers attended GSCB training events and courses. Below are comments taken from the evaluation of some of our new courses:

**Creative ideas for assessing in pregnancy.**

Gave me some new tools to use when assessing clients and also more awareness of underlying issues

This was one of the best and most informative training sessions I have ever attended. It was actually excellent in regards to knowledge, content and delivery… this training directly impacts on practitioners direct work with service users.
Annual Conference

In October 2018 the GSCB’s annual conference focussed on safeguarding children from gangs. 127 delegates attended the conference, representing a wide range of agencies including social care, schools, health organisations, Police, Probation and the voluntary sector as well as speakers and workshop facilitators.

Feedback received after the event was very positive and reflected the benefits for networking and collaboration provided by multi-agency learning events;

I was amazed with the skill set in the room and it would be a very good thing to link up with them and contact them in the future if needed.

What we plan to do next?

Moving forward into the new partnership arrangements the Learning and Development work group will no longer exist, however the work of the group will be taken forwards via task and finish groups around set pieces of work.

Learning needs analysis

For 2019-2020 we will be using a new model for Learning Needs Analysis adapted from Children’s Services. We will be looking at areas of strength and improvement to consider:

- Encouraging the exchange of knowledge, skills and experience within the network.
- Supporting this process by providing sessions on facilitation skills.
- Identifying where new learning opportunities need to be commissioned
- Thinking about different ways in which learning can be communicated

Learning from reviews and audits

In 2019-2020 Greenwich Safeguarding Children Partnership will be working more closely with neighbouring boroughs Lewisham and Bexley to ensure that local learning is collated and shared, as many children move across borough boundaries to go to schools, socialise or when moving home.

Example of effective practice

The Board have a good relationship with our Learning Management System provider and there are plans to work with them and Greenwich University on research into how the impact of training on practice and children’s lives can be most effectively demonstrated.
Child Death Overview Panel

Chaired by: Nikesh Parekh, Public Health Medical Associate

What did we do? Why?

Working Together to Safeguard Children (2018) provides the most recent framework for reviewing all child deaths at a local level, which has been a statutory duty since April 2008. The process involves:

1. A **Rapid Response Meeting** of key Professionals, within days of an unexpected death of a child, for the purpose of enquiring into and evaluating the circumstances of death. Any immediate safeguarding concerns are identified and if appropriate recommendation for a Serious Case Review or Serious Incident Investigation is made.

2. A **comprehensive overview of all child deaths** up to the age of 18 years (excluding babies who are stillborn as well as planned terminations of pregnancy carried out within the law), where the child was resident in the borough. This is undertaken on a minimum quarterly basis by a multi-disciplinary panel and involves data collection and inter-agency discussion to identify where lessons can be learnt to prevent future child deaths and improve the health and safety of children in the area. If necessary then a recommendation for a Serious Case Review (SCR) is made.

**Note:** The Child Death Overview Panel (CDOP) Annual Report 2018-2019 will be available later this year.

How have we made a difference to children?

Regular inter-agency meetings with good attendance by senior professionals ensures that the death of a child resident in the borough is comprehensively reviewed and scrutinised. Where there are lessons to be learned, these are directly actioned through the agencies represented on the panel.

Rapid Response Meetings

This year, 10 rapid response meetings were held for the unexpected deaths of children in the Borough, led by the Designated Paediatrician for Child Death Review. This enables key professionals to respond in a timely manner and share information effectively concerning an unexpected child death. One of these cases progressed to a Serious Case Review (SCR) and upon completion the case will return to the CDOP for a final review.

The CDOP reviewed 41 child deaths in this financial year. Child deaths were categorised as a peri-natal/neo-natal event (n=22, 53.7%), chromosomal, genetic and congenital anomalies (n=6, 14.6%) and sudden unexpected unexplained death (n=4, 9.8%). The remaining deaths (n=9, 22%) were categorised as infection-related, deliberately inflicted injury, suicide, malignancy and acute medical or surgical condition.

Ten case reviews were of child deaths that occurred in the 2018-2019 financial year. Reviews are delayed for various reasons including pending investigations and reports. Cases are only reviewed once all necessary information has been received and no further enquiries are pending.

Of the 41 cases reviewed this financial year, potentially modifiable factors were identified in 11 (26.8%). Learning and actions in response to these are ongoing.

What have we learned from CDOP review over this financial year?

Key learning points from CDOP review of these child deaths include:

1. Maternal (and partner) smoking during pregnancy and unhealthy maternal weight continue to contribute to adverse outcomes during pregnancy.

2. Safe sleeping advice for infants must continue to be pushed to new
parents as evidence of co-sleeping continues to found as a key risk factor in cases of sudden unexpected unexplained deaths of infants.

3. The risk of poor mental health in young people is substantially increased following adverse childhood experiences. Whilst it is critical that mental health support services are available and joined up around the child and family, public health efforts should be stepped up to better understand the epidemiology of ACEs amongst young people in Greenwich.

Learning and Impact of work

- Data on adverse childhood experiences will be collected as part of Greenwich's new integrated children's commissioning plan. This data will be used to better understand the impact locally on adverse health outcomes in young people, and to target support services to mitigate health risks.

- Midwifery staff at Queen Elizabeth Hospital have been trained on implementing a maternal risk perception tool to strongly encourage the engagement of pregnant smokers into cessation services.

- Health visitors in Greenwich are encouraging new parents to show the sleeping arrangements of the child.

What do we need to do better?

We have made considerable gains on completing outstanding child death reviews that are ready to be presented at the CDOP. However, there are still cases that are ready to be reviewed that have completed all investigations. Our aim is to reduce this number to zero.

Examples of effective practice

- Use of peri-natal mortality review tool to identify any deficiencies in healthcare provision and flag where improvements might be made.

- Holding themed panels e.g. neonatal, to focus reviews and associated discussions with obstetric colleagues for specialist input

- Greenwich CDOP has been working with Lewisham and Bexley CDOPs to align processes (e.g. all use eCDOP) and advance plans to merge into a tri-borough operation.
Case Review Function: Serious Case Reviews

Learning from Cases Work Group Chaired by: Henrietta Quartano, Senior Assistant Director
Children’s Social Care

What did we do?

The Learning from Cases Panel meets to consider referrals for Serious Case Reviews and make recommendations to the Independent Chair of the Children’s Safeguarding Board. It is a multi-agency panel chaired by the Senior Assistant Director for Safeguarding and Social Care. The panel has representation from key partners including local NHS bodies, Schools, the Police, Probation and Children’s Safeguarding services. Other panel members are invited if required.

The Panel considered 2 cases and agreed 1 Serious Case Review in 2018-2019. The Serious Case Review related to a family with multiple complex needs and a long history of service involvement. This review is now ready for publication however is being held up by parallel processes within the judicial system. Despite this delay, much learning has been taken from the review and systemic multi and single agency improvements have been made, with an action plan put in place.

Where the decision was made not to initiate a serious case review the panel carefully considered what could be learned from the case and single agency reviews and actions were agreed.

GSCB published 1 serious case review this year relating to the sad death of a child in 2016. There is one further serious case review which has been completed and action implemented, however remains unpublished due to parallel processes.

What we plan to do next?

Under the new arrangements changes have been made to the way that the partnership conducts learning reviews, as per the requirements of Working Together (2018). Serious Case Reviews are to be replaced by Child Safeguarding Practice Reviews (CSPRs).

The group has two key purposes:

1. To consider Serious Safeguarding Incidents where the abuse or neglect of a child is known or suspected AND the child has died or been seriously harmed to:
   - Review the facts about the case presented in the documentation.
   - Agree any immediate action.
   - Consider the case against the criteria for child safeguarding practice reviews.
   - Decide whether a practice review or other learning review should take place.

These meetings will be convened on a needs basis when there has been an incident.

2. To focus on capturing learning from ‘no harm’ incidents as well as good practice and to disseminate the findings in a way that is most likely to bring about improvement in practice. Any practitioner, with agreement from their designated safeguarding lead, can refer things that do not meet the threshold for a serious safeguarding incident but which they believe are important for learning to the Learning from Cases Group.

These meetings will be scheduled and held three times a year.
There is a new rapid review process which accompanies the CSPR process, in which the national panel must be notified of such cases and a rapid review meeting must take place within 15 days of notification to consider all available information and decide whether to initiate a CSPR. The rapid review should also consider whether there may be learning of national significance to be gathered. In cases where learning could have wider implications the National Panel may decide to conduct their own review which can either replace or run alongside a local review.
Communication and Engagement Work Group

Chaired by: Josh Harsant, Senior Participation Officer, The Participation People

What did we do?

The Communication and Engagement Workgroup (CE WG) exists to promote and communicate clear and consistent safeguarding messages with partner agencies and children, young people and families across the Royal Borough of Greenwich.

This year, the CE WG has continued to evolve in light of the changes to Local Safeguarding Children Boards and changes in staff in the GSCB Business Unit. The group consequently only managed to meet twice during the 2018-2019 period. The substantive discussion was around ‘what's next’ for the CE WG and its function.

Membership

Over the year, CE WG meetings have been attended by:

- RBG Children’s Services
- RBG Corporate Communications
- RBG Public Health Communications
- Charlton Athletic Community Trust
- Greenwich CCG
- METRO GAVS
- GSCB Executive (Lay Member)

Neglect Matters

Our Neglect Matters campaign with the NSPCC came to an end in May 2018. The campaign sought to raise awareness of the signs and symptoms of Neglect, so that more people speak up if they have concerns about a child.

The campaign included briefings for practitioners (including those in the voluntary sector), workshops to educate parents and carers, information sessions with young people and parents, an update of online materials and a poster campaign.

We estimate that the campaign will have directly reached 1,000 parents, carers and professionals. By extension, we estimate the campaign will have indirectly reached 5,500 people.

Get Together Festival

In previous years, the GCSB has attended the Great Get Together community festival in Woolwich. This year, we reviewed our approach. It was felt that the GSCB (a) meant relatively little to families and (b) partner agencies should be ‘front and centre’ at community events, promoting the GSCB’s key messages.

So, instead of having a stand-alone GSCB stall – we instead asked agencies in the partnership to ‘host’ GSCB materials instead. This seemed to work much better; and all agencies with a presence at the event were happy to host these materials on behalf of the GSCB.

Twitter

The @GreenwichLSCB Twitter feed is still alive! BIG thanks go to the Business Unit for their commitment to Tweeting. As of April 2019, the account had 261 followers – this represents a 93% increase (up from 135 followers last year).
According to Twitter Analytics data, from 1 April 2018 to 31 March 2018, our Tweets achieved over 18,300 impressions (the number of times our Tweets were seen by other Twitter users).

**What now?**

With the newly launched Greenwich Safeguarding Children Partnership, the CE WG will no longer continue in its current form or structure. Instead, communication and engagement activity will be reconfigured and embedded across the Partnership.
Safeguarding children from exploitation

Strategic Multi-Agency Child Exploitation (SMACE) group: Chaired by Henrietta Quartano (Senior Assistant Director, RBG Children’s Services)

The GSCB recognises that different forms of exploitation leading to abuse are often co-present in the lives of children with a strong link to children going missing, especially when this happens more than once. The GSCB decided to combine the functions of the Child Sexual Exploitation MASE and the Missing Work Group for 2018-2019; into the Strategic Multi Agency Child Exploitation workgroup or SMACE.

The SMACE is a strategic partnership group which is responsible for working collaboratively to ensure a tactical response to Child Exploitation including Child Sexual Exploitation (CSE), criminal exploitation, missing, county lines, gangs and modern-day slavery. The group focuses on prevention, intervention, diversion and disruption and monitors the progress of the Joint Targeted Area Inspection (JTAI) action plan in order to reduce the impact and risk of child exploitation across the community.

The SMACE group has met regularly. New terms of reference and membership have been agreed. The group is now functioning well with good attendance and commitment from all partners.

The work of the SMACE supports the GSCB priority of addressing the challenges and risks to children from exploitation.

What did we do?

A key activity of the group has been to monitor the actions from the Joint Targeted Area Inspection Action Plan following the inspection in February 2018.

This has included:

- Raising awareness across the partnership of child exploitation:
  - The Violent Organised Crime Unit (VOCU) attended the school Designated Safeguarding Leads’ meeting in May to raise awareness and understanding of gang activity in Royal Greenwich. The session included supporting DSL’s to spot early warning signs and highlighted the need to report incidents to the Police.
  - Early Help presented information on their work with vulnerable adolescents to the Health Safeguarding Group.
  - Awareness raising sessions with RG foster carers and our children’s home.
  - Child exploitation is incorporated into many Greenwich Safeguarding Children Board (GSCB) training courses and there are also specific courses on CSE and on-line safety.
  - Safer Communities deliver a range of courses which includes gangs, CSE and trafficking.
  - In October 2018 the GSCB held their annual conference on “Safeguarding Children from Gangs: What Works?”. The conference included presentations from national and local experts and workshops on supporting gang affected boys, supporting gang affected girls, interactive mock Greenwich Risk and Adolescents Safeguarding Panel (GRASP) and Early Help with children at risk of exploitation. The conference was
well-attended by colleagues from across the partnership and positively received.

Promoting good practice in relation to child exploitation:

- The development and dissemination of a Contextual Risk Early Identification Tool designed to support practitioners in universal and targeted services and schools to help link what may seem like unrelated concerns and a general sense of unease about the child’s welfare and to differentiate between general worrying teenage behaviour and concerns that may suggest a degree of risk, including grooming for and active child exploitation, which could be sexual as well as criminal.

- The GSCB Neglect Strategy and Practice Guidance has been finalised and widely disseminated which includes guidance on adolescent neglect and the resulting increased vulnerability to exploitation.

- The joint Safeguarding Adult’s Board and GSCB “See the Adult. See the Child” protocol has been launched which includes awareness raising for both child and adult facing services of exploitation and is underpinned by a whole family approach.

- Education is a key protective factor for all children and in the same way that safeguarding is everyone’s business, “education is everyone’s business” is being promoted across the partnership. This includes ensuring that absence of vulnerable adolescents from school is clearly understood as a risk factor.

- Guidance for all practitioners from The Children’s Society on sharing soft intelligence with the Police in relation to exploitation has been disseminated.

Other work from the JTAI Multi-Agency Action Plan that is also being progressed includes:

- A task and finish group is underway to develop practice guidance for adolescent risk. There are representatives from Health, Police, SEND, Safer Communities, Youth Offending Services and Children’s Social Care.

- A review of the Greenwich Risk Adolescent Safeguarding Prevention (GRASP) meeting has been completed and its recommendations have been progressed.

- A multi-agency task and finish group on Missing is being progressed.

- Work with the Head Teachers’ Partnership is underway to look at the use of fixed term exclusions and to develop a strategy and training to reduce their use.

At every meeting the SMACE reviews data relating to this cohort and identifies themes, is updated on intervention/disruption by the Police, reviews research and practice guidance and uses the meeting to identify and resolve any issues relating to our multi-agency safeguarding practice.

What we plan to do next?

Children who go missing, who are at risk of child sexual exploitation and who are at risk of criminal and other forms of exploitation through gangs are a complex cohort to engage with and high risk in terms of outcomes. This group of vulnerable children remain a high priority for the GSCB. Work is evolving across London to develop best
practice in relation to this group. The GSCB has engaged with the wider developments and is using good practice identified elsewhere to inform our multi-agency practice and the Knife Crime and Serious Youth Violence Task Group initiatives.
Keeping Children Safe in Health

*Chaired by:* Anita Erhabor – Designated Nurse for Safeguarding Children Greenwich CCG

**What did we do?**

In 2018-2019, Greenwich Safeguarding Children Board (GSCB) Health Safeguarding Work Group met regularly with good representation from all health services. The meetings were well attended by safeguarding leads. The Group obtained regular updates and assurance from provider organisations.

We planned, organised and implemented a successful ‘Demystifying the Paediatric Assessment’ workshop. It was a multi-agency training for Health, Education, Police and Social Care professionals who work regularly with children and young people and adults who are parents/carers. These professionals had particular responsibility for safeguarding and promoting children’s welfare and the training improved their awareness of the clinical processes around investigating Child Sexual Abuse (CSA) and Exploitation. It also provided an opportunity to learn how to use the Brook Sexual Behaviour Traffic Light tool to identify sexually harmful behaviours in young people.

During this event we also launched the CSA Factsheet, a carefully designed quick-reference and practical resource for professionals who have to make referral decisions regarding sexually related harm to children and adolescents.

Findings from the ‘Safeguarding Babies’ audit was shared across the health economy; and accordingly, we requested the development of action plans from our health providers to evidence that these findings inform practice as part of on-going quality improvement processes.

In 2018-2019, we also participated in the promotional event ‘Choose Life and not the knife’ aimed at the prevention of adolescent exploitation through gangs. GCCG funded and supplied promotional drinking bottles branded with the event slogan.

In this period the sub-group also worked closely with Lewisham and Greenwich NHS Trust Midwifery department to review their ‘maternity safeguarding’ pathway to ensure it links well with Multi-Agency Safeguarding Hub (MASH) with a refining of the threshold required for referral. The aim was to efficiently and accurately identify vulnerable pregnant women at risk. Quality visits were also carried out to assess new practice of incorporating checking baby sleeping arrangements by health visitors. Furthermore, National Society for the Prevention of Cruelty to
Children (NSPCC) ‘Handle with Care’ booklets were disseminated widely across GP practices, Children’s Centres, Community Services and Queen Elizabeth Hospital.

What was the impact?
Feedback from the ‘demystifying the paediatric assessment’ was very good. Professionals commented on how enlightening the workshop was, how clear they were about the assessment process and the identification of sexually harmful behaviours in children.

The CSA factsheet was well received and widely shared across all services including children’s social care.

What we plan to do next?
With the advent of new safeguarding partnership arrangements, the Health Safeguarding Work Group has now ceased. However, Health Safeguarding Leads will continue to meet quarterly to share good practice, identify gaps in services, learn from cases and enable early resolution of potential problems.
Keeping Children Safe in Schools

**GSCB Schools Work Group:** Chaired by Vicky Cuff, Executive Headteacher, Invicta Primary School

**What did we do?**

The GSCB Schools Work Group provides a communication channel between schools and the GSCB, information sharing amongst the schools and a source of peer support in meeting safeguarding responsibilities.

This year we have further established the Greenwich Designated Safeguarding Leads’ Network, with termly meetings open to DSLs from across the borough. The meetings are well attended by colleagues from all sectors and presenters have attended to speak on a number of topics over the year.

This year we have worked with colleagues from a range of organisations to promote and support safeguarding work relating to:

- Sexual Health
- Food Poverty
- Youth Mental Health First Aid
- Youth suicide prevention
- Supporting families and children living with Domestic Abuse and adolescent familial conflict

This year there was a section 11 audit which focussed specifically on schools, and confirmed our confidence in the safeguarding commitment and performance of the borough’s schools.

Year on year there is an overall increase in the number and range of schools responding, and staff in a wider range of roles are taking part.

Greenwich is fortunate to have a group of schools who are well engaged with the safeguarding partnership and committed to continual learning and improvement to make children safer and their futures brighter. The majority of school staff know who their safeguarding leads are and are confident in reporting any concerns that they have. There are a small number of schools who are still not responding and this will be looked at more closely in the next audit.

**What we plan to do next?**

Following a recommendation from the Learning from Cases group, the schools safeguarding group, via the DSL network is initiating a peer review of record keeping related to safeguarding and child protection.

Over 2019-2020 GSCP will be improving access for schools to Youth Mental Health First Aid training in response to the findings of the Children and Young People’s Mental Health Deep Dive project which demonstrated that school is the most likely place for a young person to look for support.
GSCB Statutory Functions
Allegations against Staff or Volunteers
Winsome Collins, Group Leader, Quality Improvement Service, RBG Children’s Services

What did we do?

Working Together to Safeguard Children 2018 guidance sets out arrangements for sharing information about allegations of abuse made against staff or volunteers working or volunteering with children. The guidance states that allegations against people who work with children should not be dealt with in isolation and that any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a coordinated manner. The London Child Protection Procedures (2017) LCPP demand that all allegations relating to people who work with children are referred to the Local Authority Designated Officers (LADO) who will assess information to determine if an investigation is required, co-ordinate and support the investigation as well as offer advice on all matters referred.

We have continued to:

Investigate all allegations relating to staff working or volunteering in Royal Greenwich including in relation to their private lives where there are concerns that a member of staff has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

We do this in order to;

- Ensure that decision making is focused on any risk to children.
- Ensure that all allegations are completed in a timely manner through close working with agency and settings.
- Ensure that parents and children are informed of the outcomes of any investigation as appropriate.
- Maintain a data base to identify trends and learning needs
- Disseminate learning across the partnership arising from LADO investigations.

The focus for 2018-2019 was to continue to provide and develop a LADO training programme across Children Social Care and the wider professional network.

There is a briefing delivered 2-3 times yearly as well as a specific workshop that was undertaken with Children Social Care.

To develop a LADO escalation process to ensure that cases where the outcome is challenged are dealt with in a fair and transparent manner.

There is no escalation process in place and this was discussed with the London LADOs to ascertain how this is managed by other local authorities. In a number of local authorities they have adopted the child protection conference appeal process and RBG will also amend this to reflect the LADO process.

To improve the timeliness of concluding the LADO process with a month.

There was a 16% increase with cases now concluding within a month which now means that over ¾ of the cases were dealt with within timescale.

There are now three part-time dedicated LADOs to include 2 part-time School Safeguarding Officers.

There were 313 contacts to the RBG LADO between 1 April 2018 and 31 March 2019. Of these, 290 were the responsibility of the RBG LADO with the remaining 23 the responsibility of the LADO in other Local Authorities. This is in an increase in contacts of 57% from the year 2017-2018.

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<tbody>
<tr>
<td>All contacts (RBG) only</td>
<td>185</td>
<td>158</td>
<td>290*</td>
</tr>
<tr>
<td>LADO Process</td>
<td>63</td>
<td>31</td>
<td>45</td>
</tr>
<tr>
<td>No LADO Process</td>
<td>122</td>
<td>105</td>
<td>235</td>
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* On 31 March 2018, 10 cases were opened awaiting a LADO outcome.
The LADOs assess all contacts and information received to determine whether a LADO process is needed. The sharp increase in the number of contacts is partly attributable to better recording and how the LADO process is captured, but may also be around professional anxiety heightened by an increased awareness of the LADO process.

In cases where it is not clear whether the threshold has been met, it might be necessary to have an evaluation discussion (by phone or in a meeting) in order to evaluate the information and consider if a LADO process is required. If a LADO process is required, an Allegation against Staff and Volunteers Meeting (ASV) must take place.

Early Years and Education remain the agencies who contact the LADO most frequently. There is a marked increase in the number of contacts from previous years in the number of contacts from schools and education, while Early Years remains broadly the same.

The increase can be attributed to better and more consistent recording of contacts from school. It should be noted that data from other Local Authorities also shows that the majority of contacts to LADO are referred by schools.

When there are allegations made by our looked after children who are placed in other boroughs; the responsibility lies with the LADO in that Local Authority. Greenwich LADO closely monitors any allegations, works closely with the child’s Social Worker and other local authority LADOs to ensure a timely and robust response. During the year there were 23 allegations made by our looked after children placed in other authorities.

Within RBG 55 contacts that resulted in a LADO process. Of these the outcomes were as follows;

![RBG LADO Outcome following ASV Meeting](chart)

<table>
<thead>
<tr>
<th>Substantiated</th>
<th>Unfounded</th>
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<tr>
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What was the impact?

Schools and education settings continue to show the highest rate of referral, this is expected as they have the most contact with our children and so is not indicative that children are more at risk in schools. Training is provided to staff in schools in relation to the LADO role. The new School Safeguarding Officer will continue to deliver training to them on safeguarding, safer recruitment and the LADO role. The direct contact from non-statutory agencies is positive and demonstrates a wider understanding of keeping children safe in settings.

There is effective communication between the LADO and professionals to ensure that the majority of investigations are progressed within acceptable time limits and that an Allegation Against Staff Meeting is well attended by the relevant professionals.

What we plan to do next year:

- To continue to provide and develop a LADO training programme across Children Social Care and the wider professional network to include education, health, nurseries and voluntary establishments working with children.
- To further improve the timeliness of concluding the LADO process within a month by possible changes to the staff ratio.
To ensure consistency of practice between the three LADOs focusing on timeliness of actions, recording and responses to management instruction.

Consistency in recording decisions for a LADO process or the reason why one is not required.

To ensure that Group Supervision sessions should include regular opportunities for moderation of cases to ensure consistency in decision making.
Effectiveness of Early Help

Chaired by/ Agency Representative: Audrey Johnson, Assistant Director Early Help and the Youth Offending Service, Children’s Services

What did we do?

The Early Help service offers the right service at the right time, dependent on the needs of the child, young person and family. For some families early help is needed following an intervention by statutory services such as children’s Social Care and the Youth Offending Service. Where this is the case families are supported as a step down to support the progress they have already made.

The service provides support to children and families with additional needs who may benefit from early help. Where a shorter-term responsive intervention is required through the Early Help service, the Connect support teams will work with children, young people and families. The Core units work with those who have more complex needs requiring intensive, whole family support. Further to this the Early Help service delivers parenting programmes and diversion group work to young people who have received a Triage for an offence, CEIAG (careers education information advice and guidance) for vulnerable groups, SENDIASS, (special educational needs advice and advocacy support), FIS (Family Information Service) and the Local Offer alongside The Point which is a multi-agency one stop shop for young people is beginning to be accessed by some families who wish to seek for support into employment. The Community Interventions team, formerly known as the Detached Youth Work Team is also within Early Help and they engage young people in the community who are involved in anti-social behaviour and low level offending.

Since the transformation in 2017 Early Help has implemented a robust workforce development programme and practitioners are now trained in trauma informed practice, restorative approaches and systemic therapeutic interventions. The training has been embedded and is supported by clinical in-reach and clinicians in each practice meeting to support the systemic lens and practice, which has been highly successful and has been embraced and embedded as a culture of practice.

What was the impact?

There was a spot check by Ministry of Housing Communities and Local Government (MHCLG) in April 2019. This went very well and representatives who attended fed back that they were confident that we are working in a whole family way and in all of the cases they reviewed they thought all the outcomes were achieved. It is of noted that they particularly liked our use of systemic practice and how this has been rolled out and embedded.

Since Early Help have moved to the FWI system and from October 2018 until March 2019 there has been:

790 referrals accepted by Early Help

Most referrals are from safeguarding and Primary schools
Improvements this year, what are we going to do next?

Further developments for 2019-2020 are to:

- Work has begun to join the MASH front door with Early Help front door.
- Develop CURB (youth crime prevention with Year 5 pupils).
- Transfer delivery of Youth Cautions from YOS to Early Help.

“I have really learnt a lot when it comes to strategies and loved the reconciliation session. Also de-escalating situations with my son has become so much easier and I feel more in control. There will be times when things are hard and in the group I had the support from others who I could relate to and you are not on your own. I would have liked the programme to be longer”. (Parent)

“The idea of connection before correction has been so helpful and the announcement week was outstanding. It has strengthened and improved the/my relationship with my child, I thought I would be judged and I was wrong. I felt safe and accepted for who I am and I will miss the Wednesday group.”  (Parent)

These sessions have been extremely helpful because I learned to express myself and communicate more. I have been getting a lot of advice and learnt a lot about knife crime, gangs and sex. The youth workers are very helpful. (Young Person)
Safeguarding Looked After Children

Bryan Edmands, Head of Service – Permanence and Care Leavers

The Permanence Service includes the ten social work teams that work directly with the children and young people in our care and our care leavers aged from 18-25 years. Additionally, the Adoption service, Fostering service, Supervised Contact service, Private Fostering service, support for Special Guardians and our residential Children’s Home are all delivered through the Permanence Service.

We remain committed to ensuring that the right children become looked after at the right time and only where this is necessary to ensure that they are safeguarded and their welfare needs are met. Since October 2017 we have implemented a weekly Placement Panel, which I co-chair with my Safeguarding service counterpart and includes leaders from Fostering, the Virtual School and our placements commissioning team. The Panel provides a high level of oversight into this critical decision while offering cross service advice and support into alternatives to care.

The looked after children number at the end of March 2019 was 479 which represented the lowest number for over 15 years with 357 children (74.5%) in foster placements.

We have an active Children in Care Council (CiCC) and over the past year this has been refreshed with the development of a Junior CiCC for children and young people in our care aged 7-13 years. We have also refreshed our Care Leavers Forum (CLF) and they were involved in the content of Our Local Offer to Care Leavers booklet. The CiCC/ CLF meet with senior figures within Children’s Services and the Cabinet Member for Children’s Services to share ideas and give feedback on their care experience. Two of our young people involved in the CiCC/ CLF have also Co-Chaired our Corporate Parenting Board.

We work closely with our neighbours in the Quad borough arrangement (Lewisham, Southwark, Lambeth) to develop good practice in family proceedings. We are involved in longitudinal research into care proceedings and outcomes, providing learning for ourselves and the judiciary. Royal Greenwich continues to be an example of good practice concerning court proceedings timescales; and we receive good feedback from the Central Family Court. The country average for final quarter 2018-2019 was 33.3 weeks and across London 33.4 weeks – and for us 30.2 weeks. Though this is an increase on timescales from last year (mainly to do with lack of judicial availability) this remains a good achievement and shows we are finalising permanence plans swiftly.

We continue to maintain good practice in adoption and offer very good post-adoption support. We compare well with our neighbours with 16 adoptions during 2018-2019; and with 25 children who became subject to Special Guardianship Orders.

Our Children’s Home received a full inspection in February 2019 and now for the fourth year running Ofsted rated Broadwalk ‘Outstanding’. The inspection report states: “Young people receive highly effective individualised care from managers and staff who understand their needs very well. As a result, young people have positive experiences in the home, grow in confidence and make excellent progress in all areas of their lives.”

We have begun the development of a new 4-year placement sufficiency plan. The new strategy will be focussed on the social work
practice which underpins safeguarding intervention and delivery of looked after children services, with a focus on practice around managing adolescent risk and reunification.

We are aspirational for our young people and want to see them achieve and have positive choices as they transition into adulthood. Although the proportion of Royal Greenwich care leavers aged 17-21 who were in employment, education or training on their birthdays during 2018-2019 has declined very slightly, our performance remains above the most recent London and national outturns. Greenwich care leavers remain more much likely to be in higher education than care leavers in London or England.

We now have new extended duties for care leavers aged up to 25 years. This change will undoubtedly see an increase in the number of young adults we work with. We are looking into new and innovative approaches to ensure we can provide the same high level of service to this expanding group.

A priority continues to be an increase in our in-house fostering provision. This remains a challenging area. However, we recognise that this is a highly competitive market and we continue to offer support for our excellent foster carers while seeking out new opportunities for recruitment. We continue to innovate in providing models of support to our foster carers and this has been recognised by the DfE in our further pioneering of Mockingbird Family Model developments.

Safeguarding children in our care remains to the forefront of all of our service delivery and over the past year there were 22 children in our care who were subject to a LADO enquiry where there was a concern as to the care and/or treatment provided them or over the placement.

The main reason given for the referral:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint</td>
<td>8</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>2</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>7</td>
</tr>
<tr>
<td>Practice Issue</td>
<td>2</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>3</td>
</tr>
</tbody>
</table>

Of these, 9 related to fostering provision and 13 to residential care. There were no substantiated allegations regarding children in our own provision.
Making a Difference to Children & Young People in Greenwich: Private Fostering

Sharon Pearson: Quality Improvement Leader Royal Borough of Greenwich Children Services

What did we do? Why?

A Private Fostering arrangement is made between the parents and the carer without the involvement of the local authority. It involves the care of a child under the age of 16 (under 18 for disabled children) by someone other than the parent or a close relative with the intention that the arrangement should last for at least 28 days. An adult providing Private Fostering may be an extended family member, a friend of the child’s family, or someone who is previously unknown to the child. The parent retains parental responsibility. The private foster carer becomes responsible for the day-to-day care of the child and must safeguard and promote their welfare.

Local authorities do not formally approve or register Private Fostering arrangements. However, the local authority must be satisfied that the welfare of children, who are or will be privately fostered in their area, is being safeguarded and promoted. The statutory duties for the local authority are:

- To promote awareness of the law relating to Private Fostering so that Private Fostering arrangements are recognised and notified;
- Following notification of a Private Fostering arrangement, to visit the private foster carer where they live, speak with the child, talk to the parent, where possible, and undertake reasonable checks as to the suitability of the arrangement; and where necessary impose restrictions;
- Identify whether the child is a ‘child in need’; requiring help as a disabled child or requiring help without which the child’s health and development will be impaired or fall below what would be expected;
- Provide advice where needed to parents and private foster carers;
- Visit the child at the private foster placement within the prescribed timescales to be satisfied the welfare of the child is safeguarded and promoted.

The Designated Monitoring Officer for Private Fostering meets quarterly with representatives from across RBG Children’s Services and from the GSCB to agree an annual work plan, monitor outcomes and identify improvement actions.

Privately Fostered Children as at 31/03/2019

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or Black British, African</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 3</td>
</tr>
<tr>
<td></td>
<td>Total 4</td>
</tr>
<tr>
<td>Black or Black British, Mixed Black</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
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<tr>
<td></td>
<td>Total 2</td>
</tr>
<tr>
<td>Black or Black British, Nigerian</td>
<td>F 2</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
</tr>
<tr>
<td></td>
<td>Total 3</td>
</tr>
<tr>
<td>Black or Black British, Other Black, Black unspecified</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
</tr>
<tr>
<td></td>
<td>Total 2</td>
</tr>
<tr>
<td>Black or Black British, Sierra Leone</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
</tr>
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<td></td>
<td>Total 2</td>
</tr>
<tr>
<td>Black or Black British, Somali</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
</tr>
<tr>
<td></td>
<td>Total 2</td>
</tr>
<tr>
<td>Chinese or other ethnic group, Vietnamese</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
</tr>
<tr>
<td></td>
<td>Total 2</td>
</tr>
<tr>
<td>White, British</td>
<td>F 1</td>
</tr>
<tr>
<td></td>
<td>M 1</td>
</tr>
<tr>
<td></td>
<td>Total 2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>
During the year ending 31 March 2019 there were 19 privately fostered children. Of those cases that ended during the year:

- 2 children reached aged 16 and the arrangement ended
- 1 child returned to live with their parent
- 1 child and their carers moved out of borough
- 1 child left the arrangement to live with a blood relative
- 1 arrangement ended as it was no longer a PF arrangement

100% of all 6 weekly and 12 weekly visits to privately fostered children were completed within timescale.

The main reasons for children being in Private Fostering arrangements are:

- Children coming from abroad to live with extended family or family friend,
- Relationship breakdown between parents,
- Parent being in prison,
- Parents’ immigration status,
- Parents’ working unsocial hours.

Private Fostering is a short term arrangement, hence the cohort changing over the year. However, this can also be a long term arrangement. Should this be the case, carers are usually encouraged to seek permanency for children through Special Guardianship or Child Arrangement Order.

Consideration of permanence in promoting stability for children in Private Fostering arrangements continues to remain a focus for social workers. This year Private Fostering arrangements alongside making sure those children are seen and able to talk to a social worker where it is known or believed a child is living in a Private Fostering arrangement. There remain relatively few notifications of Private Fostering arrangements.

A clear barrier to identification is concerns about immigration status and ‘the authorities’. We have sought to promote awareness of Private Fostering and the responsibility to notify the local authorities as a safeguarding not an immigration issue. Information about Private Fostering is targeted to those who have the greatest reach in the community. If notification clearly identifies the case as a Private Fostering arrangement then the initial visit will be undertaken by the Fostering Team. If it is unclear that the arrangement is Private Fostering then the visit is carried out by children’s social care Assessment and Support Teams in order to determine status of the case.

Responsibility for subsequent visits to children in Private Fostering arrangements and taking action to safeguard children and support carers occurs within the Fostering Service. With the Private Fostering being managed within one service there continues to be a strong focus to Private Fostering, and it affords and equip workers to gain a better understanding about what Private Fostering involves and is a lot more competent to advise and offer needs led support for Private Foster carers which has clearly improved performance in meeting statutory timescales.

Most children are seen within the required timescale and this is particularly evident in the 6 weekly visits where 100% are seen and visited on time. The 12 weekly visits are a 100% and subsequent visits are within timescale. Most children who are living in Private Foster arrangements are seen within the required regularity.

Performance has continued to improve. All children are seen. A small number of children are identified as being children in need and are receiving the appropriate support services.

**How have we made a difference to children?**

**What we have done**

Continue to encourage more Private Foster carers and parents to promote permanence for children, so that they can feel secure and understand the arrangements they are in.

Since the Private Fostering arrangements are now with the Fostering Service there continues to be better tracking, monitoring and reporting of a privately fostered child and also an improvement in the performance of visits.
We have on-going awareness raising campaign amongst professionals through quarterly private fostering multi-agency training, as well as publicity awareness within the community through stall display in libraries within the borough, leaflets distribution, screen display at the General Gordon Square and the Corporate reception at the Woolwich Centre.

**What have we learned?**

By continuing to promote Private Fostering as a safeguarding issue along with concerns about child trafficking and child exploitation so that parents, Private Foster Carers and local communities understand why complying with the law is important.

**What do we need to do better?**

We need to continue to support a child and carer to attend meetings with CAMHS.

We need to continue to advocate on behalf of families with other agencies for example Housing; Nil Recourse Team; Courts and the Benefits Agency.

We need to liaise with schools to support the children's education and ensure they are accessing the support they need. Help carers enrol toddlers at nursery provision.

We need to ensure that the children are registered with a GP, dentist and opticians in order to have basic health and medical needs met.
Making a Difference to Children & Young People in Royal Greenwich – Partner Agencies
Children’s Services are responsible for the range of universal, prevention and statutory services and have an important interface with Early Years settings, schools and sixth form provision. We champion the needs of vulnerable children whether that be for children with Special Educational Needs and Disabilities, whether they need support through our Early help services, we need to protect them from harm, or they are children in our care. Alongside the work and priorities for the Safeguarding Partnership our priorities and performance are set by the Children and Young People Plan (CYPP) 2017 – 2020.

The Children and Young People Plan sets our vision which places children at the heart of all we do and has four areas of focus known as the fundamentals for the children’s partnership. The fundamentals relate to the partnership’s core business for improving outcomes for all children:

• Strong Foundations: we want all children and young people in Greenwich, whatever their background or circumstances to have the best possible start in life, particularly during their first 1001 days. Greenwich is a forward-looking area for education, and we want all children and young people to have aspiration, and to be supported by effective support services, resilient families and good schools. We want them to have ambition to achieve throughout their education, to reach their full potential and to make the most of opportunities available from living in Royal Greenwich and in London. We want them to not only be healthy and well but to have a sense of belonging, to feel safe, supported and secure in their families and their community. This will help children cope with and bounce back from challenges they encounter as they grow up.

• Prevention: we believe that a good education together with supportive parents or carers gives children the best chance to flourish. Some children and families will need more support than others. For them we will have more chance of helping them make sustained change in their lives if we intervene early to help them regain their resilience and overcome challenges. It is important that the right help is provided at the right time for children to get back on the path of achieving their full potential.

• Safe and Secure: some children need a lot more help than others. Children with special educational needs and disabilities, children in care, care leavers and those who are at risk of significant harm will always be a priority for us. It is crucial that children who face the most challenges in life get the right education and support to achieve their full potential.

• Resilience and good mental health: this is a cross cutting fundamental recognising the importance of resilience and good mental health for all children.

The plan also sets out four CYPP Priorities, which are focused on addressing historic underperformance and trends, which we know relate to specific groups of children and young people and therefore are focused on improving outcomes for these cohorts. Each of the four priority areas is being led by a member of Children’s Services Directorate Management Team and a senior officer from the Children’s Services Strategic Partnership; the four priorities are:

1 - Strong Foundations for children from disadvantaged backgrounds

2 - Supporting disadvantaged boys and engaging well with men

3 - Healthy relationships, tackling violence and exploitation

4 - Children with Special Educational Needs and Disabilities
We are pleased with the progress made since the implementation of the Children and Young People’s Plan. We have strengthened the Early Help offer and at any one time there are around 500 children receiving early help, with the interventions delivered being of differing length and intensity dependant on the complexity of need. The service has developed a systemic goal-focused intervention model with the emphasis on interventions to meet the changing needs of families, and encouraging the formation of hypotheses, reflection and analysis to improve impact on children’s outcomes in a sustained way. Whole family work promotes empowerment and resilience and prevents escalation to social care.

The continuing development and strength of this model is reflected in the improving figures with respect to the proportion of children stepped down to Early Help who remain below statutory thresholds. The sustainment of positive outcomes of children that cease to be supported by Early Help continues to be very high when tracked over six months.

The longer-term trend for child protection numbers remains a downward one and our rate per 10,000 is consistently below London and England comparators.

Our Safeguarding arrangements are robust, and we know our services well. Repeat plans within two years did see a small increase in 2018/19 but this is back down.

The child protection tracker group rigorously monitor all repeat plans as well as the length of time children are subject to a plan, with a particular focus on any plans that last for two years or more as this would mean CYP suffering or likely to be suffering significant harm for a prolonged period.

We continue to see a slow and steady reduction in the number of children in our care, and this has been the case despite a significant increase in the number of Unaccompanied Asylum Seekers over the past 12 months. Whilst our rate per 10,000 remains above comparators it is reducing steadily.

Placement stability continues to be better than the England average.

A recent report published by the Children’s Commissioner that looks at all aspects of stability for children in care (so placement moves, school moves and social worker changes) shows RBG achieves well across the range of measures they use.

As we move into the third year of delivery against the fundamentals and priority areas of work it is increasingly apparent for the need to align the business plans between those of the Safeguarding arrangements and the wider outcomes for children young people and families.

We have worked hard at ensuring we have the new Children’s Safeguarding Partnership arrangements in place which were published in June 2019. These new arrangements provide us with an opportunity to take stock, work together to see where our priorities overlap and where we need to maintain separate focus. For example, the growing need to understand and do more in the area of adolescent safeguarding is an area that is multi-faceted and only through a collective joined up response will we make lasting and sustainable impact on reducing the risks young people are vulnerable to.

Over the coming months we will provide a range of workshops and focus groups to better align the Safeguarding arrangements and the Children and young peoples partnership and ensure that we reduce any duplication, we focus our efforts on where it is most needed and strive to continuously improve outcomes while retaining a relentless focus on child protection and safeguarding children in Greenwich.
Royal Borough of Greenwich Health and Adult Services
GSCB Executive Board Member: Simon Pearce, Director of Health and Adult Services

What did we do?
Health and Adult Services (HAS) provide social work and care management assessments and support adult service users in the borough, many of whom are parents or have childcare responsibilities.

The Children's and Adult's Safeguarding Boards have continued to work closely together with the Chair and Board Managers in regular contact with one another, and undertaking work in respect of key issues such as producing the See the Adult See the Child Protocol and videos on Domestic Abuse. A conference on Domestic Abuse was also held and staff from across children's and adult's services and partner agencies attended. In 2019-2020 the Safeguarding Adults Board has identified Transitions as a key area of work and a further conference is being planned.

A Joint Strategic Partnership Meeting was held in January 2019 to share updates, discuss matters arising and changes in the partnership and to agree further collaboration arrangements.

There have been closer ties between the SAB and GSCB Learning & Development sub-groups as there are nominated reps from each Directorate to attend those sub-group meetings.

The Principal Social Worker has worked with the Learning and Development Team to undertake a learning needs analysis in relation to Child Safeguarding. This will inform future mandatory training programmes for staff.

Staff use the “See the Adult See the Child” protocol to ensure that they view families as a whole rather than simply focussing on adults at risk.

HAS representatives attended the GSCB Annual Conference concerning Gangs and disseminated learning through management team meetings to individual teams.

The Safeguarding Adults Team consistently supports the MASH, Channel Panel and MARAC through the provision of case information.

HAS was represented on the GSCB executive board and will continue to be represented on the Development, Monitoring and Challenge Partnership within the new multi-agency child safeguarding arrangements.

The CLDT Transition Team works closely with the Children’s Disability Team in matters of Safeguarding.

A Joint Strategic Partnership Meeting was held in January 2019 to discuss matters arising and changes and to agree further collaboration arrangements.

What was the impact?
The learning and development team now have a clear understanding of the learning needs of adult service staff which will enable them to commission a more effective training programme.

Staff now have a better understanding of how to assess risks within families as a whole rather than focussing only on individual adults.

Teams have a better understanding of the risks associated with gangs and how these risks can impact on children and young people.

Systems are in place to ensure that information is shared with relevant multi-agency panels in a clear, consistent, accurate and timely manner.

HAS representation on the GSCB (which is reciprocated on the SAB) ensures close
communication at a strategic level and helps ensure consistency in terms of output, such as Annual Reports and other strategic documents.

What we plan to do next?
We intend to continue with the implementation of a revised Child Safeguarding Training Programme.

We would like to hold another joint conference with the Safeguarding Children Partnership.
Lewisham and Greenwich NHS Trust

GSCB Executive Board Member: Belinda Chideme – Trust Lead Named Nurse for Safeguarding and Young People

What did we do? (in relation to safeguarding children or to support the GSCB priorities 2018-2019)

Safeguarding training guidance is in place to ensure that staff including volunteers, are trained and competent to be alert to the potential indicators of abuse and neglect in children as well as knowing how to act on concerns. Training is monitored and reported on a monthly basis by the Training Compliance Team.

Following a review undertaken by the Trust Lead Named Nurse, training currently includes:

- An initial introductory and signposting exercise as part of the corporate induction program for all new staff joining the Trust.
- Level 1 is available face-to-face and online for all staff.
- Level 2 online or face-to-face for clinical staff.
- Level 3 now exists as one session as outlined in the intercollegiate document. The branding of core and specialist no longer exists. To strengthen competence Level 3 is not available online.
- A variety of LSCB subject specific trainings delivered to a multi-agency audience.
- In maternity – the team also offer a programme of safeguarding training including a safeguarding scenario on the obstetric emergency scenario skills day (PROMPT) and on Mandatory Training.
- There are safeguarding huddles in the maternity clinical areas with a theme of the month and a half day MDT Safeguarding Table Top exercises workshop.

Audits

Several audits were placed on hold because of very limited capacity in the team. Limited capacity led to the closure of one of the offices and this was put on the Risk Register. The plan for 2019-2020 is for a new and extensively revised audit tool to be used. The intention is to measure the impact of training and supervision over a three-year period. Audits will be revised as outlined below:

- Safeguarding Supervision Audit – Auditor will audit 20 records pertaining to children who were identified from SCR/ SI or other safeguarding related incidents.
- Training – Auditor will audit 50 evaluation forms immediately after a training session and benchmark against a similar evaluation sheet sent out at least 3 months after training.
- Trust Wide Documentation – Auditor will audit 5 records from Health Visiting, School Health Service, QEH ED and UHL ED – looking at a 3 year period.

The team (maternity and safeguarding children) also had interaction with KPMG who were commissioned to undertake an internal Trust audit of ED presentations from both hospital sites.

The maternity safeguarding team have continued to undertake audits specifically for maternity. Audits carried out by the Maternity Safeguarding Team are:-

Evidence for and evaluation of effectiveness

Audits undertaken by Maternity
• FGM audit
A positive point from this audit is that all women identified as having FGM were appropriately referred; using the correct method and this was documented on individual I-care records in all cases.

• MASH audit
• Record Keeping audit
• Postnatal audit

Work in relation to current GSCB Priorities
Level 3 training now includes a session delivered by a Specialist working in child sexual exploitation. The plan is to have a Specialist deliver a session every month for a year.

Level 3 training now includes a session delivered by the Named Nurses; the session is dedicated to disseminating learning from local serious case reviews. The plan is for the Named Nurses to deliver a session based on 2 reviews which involve children who were known to Lewisham and the Greenwich hospital/services.

An enhanced training and audit work plan aimed at reviewing and addressing/resolving issues in regard to safeguarding incident forms submitted by frontline staff and the safeguarding team.

A robust work plan outlining all the activities, challenges and action plans being undertaken by the safeguarding children team to be drawn up by the Trust Lead Named Nurse. The work plan will outline and track how the service is ensuring the Trust is meetings its S11 duties.

What we plan to do next?
1. To continue to build frontline staff knowledge and competence in the early identification of vulnerabilities and thereby enable a quick response (early intervention).

2. To review and strengthen safeguarding processes, safeguarding supervision and practice within maternity services.

3. To develop a robust training strategy (trust-wide) which demonstrates responsiveness to the ever-changing safeguarding agenda – i.e. share learning from Serious Case Reviews and audits to improve practice.

4. To ensure appropriate activity databases are in place to accurately capture and assess emerging themes from ED attendances and maternity safeguarding services.

5. To work in collaboration with, and to help support the revised school health service team.

6. To strengthen safeguarding supervision provision and embed a new enhanced (multi-agency) supervision model.

7. To continue to roll out safeguarding supervision across site for community midwives and specialist midwives.

8. To raise the profile of contextual safeguarding and an understanding of early help services, across all sites.


10. To ensure Safeguarding Policies are up to date.

11. To review and strengthen frontline staff knowledge on FGM and Harmful Practices.

12. To participate in partnership initiatives aimed at supporting children and young people at risk of child sexual exploitation, gang/ youth violence activity, missing and trafficking.
13. To maintain the integrated structure for Adult and Children’s Safeguarding Assurance Framework.

14. To encourage a safeguarding culture which promotes the engagement of children and young people i.e. an understanding of the importance of the voice of all children, including children with complex health and social needs.
What did we do?

In support of the GSCB priorities for 2018-2019 to improve adolescent mental health, Greenwich CCG (GCCG) as lead commissioner initiated ‘Kooth’ an online counselling service for Children and Young People (CYP) commissioned across the Sustainability and Transformation Partnership (STP) thus increasing the number of mental health services available to young people in Greenwich and also improving access. As part of the STP, GCCG jointly commissioned with Bexley and Bromley in partnership with Oxleas NHS Foundation Trust; a new Specialist Perinatal Mental Health Service. Additionally, the CCG now offers a CYP mental health crisis liaison service available at the Queen Elizabeth Hospital for Greenwich children and young people.

In further support of the other GSCB priorities for 2018-2019, GCCG funded the acquisition of National Society for the Prevention of Cruelty to Children (NSPCC) ‘handling babies with care’ leaflets to be distributed across all services working with children and their families in the borough. The CCG also part-funded promotional material in support of a campaign aimed at reducing youth gang involvement in Greenwich. GCCG also continues to fund two health professionals within the Multi-Agency Safeguarding Hub (MASH) team supporting multi-agency assessments.

Four serious case reviews (SCRs) were published in 2018-2019 and in response to the themes that emerged from these reviews, the CCG implemented learning events focused on preventing abusive head trauma in children which were directed at GPs, practice staff, Health Visitors, Midwives and Children’s Centre Staff. These were all part of our strategic approach to raise local awareness of the need to handle babies with care to prevent child deaths. Significant progress was also made in ensuring that health visitors make certain that the sleeping arrangements of all babies are adequately assessed and monitored as part of routine practice.

Through the Child Death Review process we also identified other areas requiring professional learning and quality improvement; and these were addressed through a learning event aimed at health professionals.

The GSCB priorities were effectively embedded in the quarterly level 3 safeguarding training the CCG provides to GPs, their practice staff, GP trainees, Community Pharmacists, Military Personnel, the Beresford Project Drug and Alcohol Team and the Bariatric Service Team. This represented the widest professional reach we have ever had at our training sessions. Positive feedback provided by course participants highlighted that the training was well received and would subsequently inform clinical and other care related practice.

During this period, the CCG carried out quality visits to local GP practices and the Children’s Community Nursing Team to monitor progress made against safeguarding standards in the GSCB priority areas; and to provide support accordingly.

What we plan to do next?

GCCG will embrace the new ways of working set out in the Safeguarding Partnership arrangements. This will mean refining existing pathways and developing new ones in line with the GSCP priorities (which remain unchanged for the 2019-2020 period).

We will establish new relationships and cultivate new links to further strengthen our robust inter-agency working.
Additionally, we will continue our efforts to ensure that the new tri-borough Child Death Overview Panel (CDOP) arrangements work effectively. In 2019-2020, we will work with the new safeguarding partnership to offer learning activities to front line practitioners and support the embedding of the new threshold document in practice.

**Examples of effective practice**

Lessons learned from serious case reviews and child death review process has led to a significant change in the professional practice of Health Visitors. Going forward, health visitors are now to make certain that the sleeping arrangements of all babies are adequately assessed and monitored as part of routine practice to prevent child deaths as a result of co-sleeping or unsafe sleeping environments.

Through the commissioning of additional services for child and adolescent mental health and emotional well-being, there has been an increase in access rates of CYP with a diagnosable mental health condition to mental health services – in 2018-2019 Greenwich exceeded the 32% target, with an access rate of 34%.
Oxleas NHS Foundation Trust

GSCB Executive Board Member: Stephen Whitmore, Director Children & Young People’s Services

Oxleas NHS Foundation Trust provides local NHS services in South London and Kent. Greenwich Adult Community and Mental Health Services and Trust-wide Adult Learning provide a range of physical health and specialist mental health services in both community and hospital settings. Oxleas Children and Young Peoples Directorate provide CAMHS services, Public Health Nursing 0-19 year (Health Visiting and School Nursing) services and, specialist children’s services including community paediatric and LAC services.

Oxleas vision and the challenge for safeguarding children remain unchanged; that is to ensure safeguarding and promoting the welfare of children is embedded across every directorate and in every aspect of the work of the trust.

Challenges and priorities for this year (2019-2020)

- Focus on raising awareness and increasing practitioner confidence in respect of recognising and responding to neglect, CSE, exploitation through association or involvement with gangs (county lines) and children missing from home, care or education.
- Promote use of the new Safeguarding RiO forms in children’s and adult services.
- Produce an improved safeguarding children data set.
- Raise awareness of the particular vulnerabilities of children under 1 year of age.
- Promote ‘Think Family’ in adult-focused services to always consider the needs of children in their client network.
- To promote a culture of learning, to set up joint learning events for adult and children’s services.

Plans

- To increase opportunities for ad hoc Oxleas multi-agency safeguarding supervision sessions when a child is raising concerns across multiple Oxleas services.
- To further develop the Oxleas lead professional role for children with complex health needs (CYP priority 4).
- To raise the focus of father inclusive practice within CYP services (CYP plan priority 2).

What did we do and what was the impact?

Across the year we have assured Oxleas representation at GSCB board meetings and GSCB sub-groups. We have actively participated in multi-agency audits, Serious Case Reviews and a variety of GSCB multi-agency training courses which included developing innovative new courses with our partners such as “Keeping babies and young children safe” and “Children with Disabilities” (CYP plan priority 4).

We have provided workshops to all 0-19 and specialist CYP teams to ensure practitioners are confident to use the Greenwich neglect toolkit and have evidenced its use within referrals to MASH. Feedback from therapist: “I am now more confident to identify signs of potential neglect in clients.”

We have updated Oxleas policies and procedures and training packages to reflect key changes within the Working Together 2018 guidance. In addition a new Oxleas online domestic abuse (DA) training package is shortly to be launched, to be accessed by
adult and children directorates across Oxleas, this clearly stating the impact of DA on our children and YP (CYP plan priority 3).

Our school nurses are piloting a new case conference report which provides holistic health information including the child’s voice. We have developed the Oxleas Safeguarding Children intranet site to better support safeguarding children practice; staff have reported that they find the intranet site easy to use and that this supports their understanding of key safeguarding issues.

We have improved recording and quality assurance of children’s social care referrals. There has been an increase of 19% referrals from 83 (2017-2018) to 99 (2018-2019) demonstrating an increase in confidence and awareness of risk.

A trust-wide learning event was held on 30 November 2018 to share the learning from serious incidents and serious case reviews with clinicians from both CYP services and adult mental health. The focus was on abusive Head Trauma, the Role of adult mental health staff in Safeguarding Children; learning lessons from SCR Child V. In addition CAMHS held a one day event for all staff which included training on vulnerable adolescents and county lines linked to findings from the 2018 JTAI.

Oxleas has a core role within the Greenwich Risk Adolescent Safeguarding Prevention and Protection Panel (GRASP). This is now consistently attended by our CAMHS Liaison and diversion specialist who works closely with the Oxleas Children’s Safeguarding team enabling them to disseminate information to relevant Oxleas services for consideration of the holistic needs of vulnerable young people (CYP plan priority 3). We have a core role within the Maternity concerns meeting in relation to adult mental health services.

We have evaluated our CYP supervision offer – quote from supervisee from audit: “Working with other care providers outside of Oxleas has made me realise how good our safeguarding processes are”.

We continue to embed a ‘Think Child, Think Parent, Think Family’ approach in adult services by offering ‘drop ins’ for inpatient and community settings allowing practitioners opportunities for case discussion or ad hoc safeguarding children updates.

Oxleas continues to demonstrate excellent training compliance with core updating expectations, aligned to the Intercollegiate Document. The following mandatory updating compliance levels were evidenced across the trust as a whole at the end of March 2019:

### Examples of Effective Practice

<table>
<thead>
<tr>
<th>Updating level/ requirement</th>
<th>Compliance rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>97%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 Core</td>
<td>88%</td>
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<tr>
<td>Safeguarding Children Level 3 Specialist</td>
<td>87%</td>
</tr>
<tr>
<td>Prevent Awareness (levels 1 &amp; 2)</td>
<td>99%</td>
</tr>
<tr>
<td>Prevent Practice (WRAP)</td>
<td>93%</td>
</tr>
<tr>
<td>Safer Recruitment &amp; Selection</td>
<td>90%</td>
</tr>
</tbody>
</table>
Greenwich Police are committed to safeguarding children and young people. Our ambition is to provide better outcomes for the most vulnerable people in our communities by keeping them safe from harm. The delivery of Safeguarding is considered a core component of policing but inevitably it crosses over into other areas of activity in the Police Service as well as a direct focus in the new established South East BCU Safeguarding Hub.

The Violent Organised Crime Unit (VOCU)
The VOCU’s remit includes safeguarding young people being recruited into gangs, who go on to be missing from home or care and young people becoming victims of gang-related violence or intimidation. By conducting home visits with children and their parents the VOCU gather relevant information which would be shared via Police Systems for long term support and awareness with partnership engagement. Officers will listen and provide the relevant safety advice/support referrals if the subject expressed the wish to exit a gang.

The Home Visits also provide reassurance as well as reality to the child, detailing the consequences in an effort to deter them from criminality. Where required the information is shared through the monthly Serious Youth Violence (SYV) Panel meeting so all partner agencies are actively involved in the overall support to the child, who may have become involved in gangs, as well as the mechanism to identify potential gang risks to any siblings. This forum also provides overall support options to parents and carers including information about county lines and CSE, detailing what they should look for and how they could best safeguard their child. A dedicated PC attends schools (particularly those identified as having CSE/ CL recruiters) to present on the dangers and how to negate them. The VOCU have proved critical in developing effective, sustainable working relationships to minimise harm to young people who were reported missing, and will take proactive accountability if county lines/ human trafficking investigation is involved.

Multi-Agency Safeguarding Hub (MASH) and Youth Offending Service
Police officers within the MASH team work in partnership with children’s social care, health, housing and the MPS Child Abuse Investigation Team, delivering early intervention.

Since the BCU transformation there will also CAIT referral officers and PCLOs within the MASH to allow rapid information sharing between agencies to enhance the safety of children, and where absolutely necessary facilitate children being removed from unsafe environments.

As areas of learning are identified, including through Serious Case Reviews, these are shared throughout the MASH to frontline officers and within the community. The team now delivers on Operation Encompass which was incorporated and went live in January 2019. This provides information to participating Greenwich schools of any domestic incident that has occurred, where a child in their school was present when police attended. This allows them to ensure that the child is supported and monitored.

The MASH has been enhanced with the inclusion of CASO referral and PCLO teams – case conferences are progressed quicker and Social Worker interaction is face to face, leading to closer inter-departmental working between MASH police and CAIT. It also drives smoother information sharing and swifter outcomes.
The drive for 2019-2020 is to examine more cases to identify and support a greater number of vulnerable children within Greenwich; this is currently on target. YOS are also within close proximity to the MASH, forming strong partnership working between YOS police and social care and ensuring safeguarding concerns are shared through the MASH and protective/support plans created quickly.

**Working within schools**

Safeguarding is the Schools Officers’ main role. Greenwich have dedicated Safer Schools Officers, who regularly interact with pupils through work with the pastoral staff of all secondary schools in the borough and at safeguarding meetings, assemblies with teachers, pupils and parents. By interacting through school youth council meetings and surgeries the Schools Officers listens to student concerns, identifies and addresses children who come to notice in relation to going missing, drugs, CSE, gangs, knife crime or DV. The most high risk cases are referred to the weekly GRASP meetings at the Woolwich Centre. The cases are discussed with senior professionals within services including Early Help, Social Care, YOS, CSE leads, Police Missing teams, Trilogy Plus and Charlton Athletic mentoring and engagement. Care strategies are then set in these meetings to ensure there is safeguarding grip around risk. The RBG Schools Officers conduct knife arches and weapons sweeps regularly, resulting in the capture of 12 knives from children in schools this past year. There is a continued link in with YOS for the appropriate action taken. There have been 16 young people convicted for a violent disorder matter and joint partnership working was paramount to achieve this. The intervention continues after arrests with engagement/division sessions to ensure the children continue to keep out of trouble. This includes cadet nights, which children coming to police notice are encouraged to enter.

**Identifying and addressing CSE/ Missing**

Since September 2018, Greenwich police has become the S/E BCU incorporating Bexley and Greenwich. As a result the BCU now has a dedicated CSE and Missing Unit who focus on Contextual Safeguarding. Significant work has taken place regarding Child Sexual Exploitation (CSE) and Human Trafficking within the Borough; and the dedicated teams have established clear reporting pathways and a structure for referrals to assist partners. New Missing policy identifies robust supervision and proactivity with prevention for missing people. Greenwich GRASP has a weekly and monthly focus on contextual safeguarding with the right membership to prevent, protect and avoid. The centrally based Sexual Exploitation Team has focuses in targeted areas of Greenwich, particularly Woolwich Town Centre, and covert and overt tactics are regularly deployed to best police the area. Police and RBG continue to have a good relationship with the Metropolitan Police’s centrally based Sexual Exploitation Team who have delivered training to every Schools Officers in the Borough to assist in identifying young people who may be subjected to CSE. Greenwich Police have developed a training package for Borough Officers. Pathways for officers to make referrals were developed with the MASH team.

**Child Abuse Investigation Team**

During the period 2018-2019 the Child Abuse Investigation team or CAIT (also known as Child Abuse and Sexual Offences – CASO) have dealt with a large variety of professional requests. These have included attending strategy discussions, joint agency investigations under Section 47 and also advising on single agency investigations for RBG. In doing so CAIT continued to provide a strong supporting role to children’s social care during this period. This was evidenced by the amount of positive outcomes for children in Greenwich borough by CSC and CAIT working together to establish the facts; and put in place suitable protective measures and responses to safeguarding concerns. We worked with CSC using their information based on the signs of safety model (SoSM) to establish what levels of risk were being addressed and discussed.
CAIT dealt with concerns relating to sexual abuse, physical abuse, neglect and emotional abuse of children within the family unit by reviewing crime allegations and interviewing parents and adults linked to the children at risk. These interviews were conducted using both their powers of arrest or by inviting the adults who were under investigation to an interview. This is where the person is not formally arrested, but is interviewed to the same high standard as with an arrest. They also have the same rights and protections within the Police and Criminal Evidence Act 1984 (commonly known as PACE 1984). The findings of these investigations are then used to cascade vital information to colleagues within CSC, to help them review and effectively manage the risk to vulnerable children. Hundreds of strategy meetings were held during this period, both face to face and via conference calls. The impact of this joint partnership working was clear, with managers from CSC both in MASH and the assessment teams praising CAIT for their continued advice, guidance and strong support.

CAIT continued to be part of the child death overview panel, which involved them investigating Sudden Unexplained Death in Infancy (SUDI) cases, under Project Indigo. Where possible CAIT provided a physical presence at homes and other locations to aid CSC colleagues in assessing the risk to children. Hundreds of strategy meetings were held during this period, both face to face and via conference calls. The impact of this joint partnership working was clear, with managers from CSC both in MASH and the assessment teams praising CAIT for their continued advice, guidance and strong support.

CAIT continued to support the safeguarding Board’s vision of identifying and reducing levels of neglect and abuse of children. By working closely with CSC colleagues CAIT remain a strong component in promoting child safeguarding within the Royal Borough of Greenwich. CAIT include the voice of the child in all business areas. It forms part of all discussions with families, carers, children and young people. This ensures that CSC colleagues and other professionals have the correct information to help make decisions on the appropriate level of intervention for the children that they deal with.

In March 2019 CAIT moved to become part of the Greenwich enhanced MASH team. The already established MASH and senior leadership police teams worked with CSC partners to implement this change. With the help and support of the GSCB and CSC DMT the new enhanced MASH is now fully up and running. This means that the CAIT referral desk and PCLOs for Greenwich are co-located and available to the MASH team and all the managers, social workers and staff across Children's Services. They provide quick face to face discussions on a variety of issues relating to children’s welfare. The teams have given strategy advice to allocated social workers, managers and staff to provide the highest levels of information and advice.

Work volumes through CAIT and MASH as a whole remain challenging; Merlin reports and referrals have steadily increased through 2018 and 2019, and the trend looks to continue into 2020. Briefings to promote the new enhanced MASH to CSC colleagues have already taken place, and more are being considered in the next period. We believe that this has been a very positive year for CAIT.

Strong partnership working has been delivered whilst CAIT and other specialist police departments have overcome the logistical and personal challenges due to the merger of the three separate police boroughs of Greenwich, Bexley and Lewisham; which now form the new South East Basic Command Unit or the SE-BCU.
The role of the National Probation Service (NPS) is to protect the public, support victims and reduce reoffending. It does this by:

- assessing risk and advising the courts to enable the effective sentencing and rehabilitation of offenders
- working in partnership with Community Rehabilitation Companies (CRCs) and other service providers
- managing offenders who pose the highest risk of harm and who have committed the most serious crimes in the community and before their release from custody.

In carrying out its functions, the NPS is committed to protecting the right of a person, whether an adult or a child, to live in safety, free from harm, abuse and neglect.

The National Probation Service recognises that safeguarding is everyone’s responsibility and that children are best protected when professionals are clear about what is required of them individually and how they need to work together. The Children Act 2004 places a duty on the NPS, together with other organisations, to ensure its functions, and any services that it contracts out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

NPS work on child safeguarding should also reflect the organisation’s values:

**We believe in the capacity of people to change** – we know that through excellent professional practice, strong partnership working and by making clear what is expected of offenders, we can help them change their lives.

**We are accountable** – we are proud of our role in protecting the public, which is always at the heart of our decisions.

**We are collaborative** – we work with individuals and with national and local services to create a real and sustained difference.

**We are effective** – our work is focused on delivering results, building on our skills and experience, and embracing evidence and innovation to provide a service the public can be confident in.

**We are fair** – we value the diversity of our staff, our communities and individuals, knowing that this strengthens our ability to be responsive and affect real and long-term change in how people live their lives.

**We are professional** – we trust and support our staff to make the best decisions for public safety, investing in their ongoing development, encouraging innovation and always striving for excellence.

During the course of their duties, NPS staff will come into contact with offenders who:

- have offended against a child;
- pose a risk of harm to children even though they have not been convicted of an offence against a child;
- are parents or carers of children; and/or
- have regular contact with a child for whom they do not have caring responsibility.
Staff are, therefore, well placed not only to identify offenders who pose a risk of harm to children, but also to identify children who may be at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour and other poor outcomes. It is important that, at all stages of the offender’s journey, NPS staff are aware of their roles and responsibilities in respect of safeguarding children. This applies from the pre-sentence stage, through the court allocation process, and on to management in the community following release from custody or as part of a community order.

What did we do in 2018-2019?

NPS have a dedicated Probation Officer working as a Safeguarding SPOC to deal with all Safeguarding queries within required timescales of the MASH framework.

NPS have a Probation Officer seconded to the Youth Offending Service to improve transition from youth to adult services.

From HMIP Inspection published in May 2019; inspection from January 2019: Officers engaged well in the assessment and planning stages of supervision and offending-related needs were appropriately considered and analysed.

What do we plan to do in 2019-2020?

NPS Greenwich staff are expected to attend local Greenwich Safeguarding Children training, often related to their specialist role such as Gangs or Domestic Abuse, to strengthen existing relationships between agencies and increase knowledge.

From HMIP Inspection published in May 2019; inspection from January 2019: we will ensure that risk of harm is fully considered and assessed in all cases, including to children and victims, using all relevant assessment tools, including ARMS.

To develop an administrative process to deal with MASH Safeguarding requests for information.

To ensure all staff have completed national training on Safeguarding Children and Domestic Abuse.
What did we do?
METRO GAVS provides infrastructure support to the voluntary sector. As such, METRO GAVS has no direct contact with children and young people but works with local voluntary groups to better support and safeguard children and young people in the borough.

In 2018-2019, METRO GAVS continued to represent the voluntary sector on the GSCB Executive Board, and contributed to the GSCB’s sub-groups including Engagement and Communication, Audit, and the Multi Agency Child Exploitation Work Group (MACE).

METRO GAVS contributed to the Deep Dive audit on how well services within the borough are supporting children to achieve and maintain positive mental health. Following the learning and recommendations from the Deep Dive audit, we held a workshop on children and young people’s mental health for the voluntary sector facilitated by Time to Change. Forty groups from across the borough attended the workshop. We cascaded the Self-harm and Suicidal Ideation Protocol, Children and Young People’s Mental Health and Wellbeing Symptoms and Services Guide and the GSCB/ SAB See the Adult, See the Child protocol.

We continued to provide safeguarding training for groups and volunteers who find it difficult to attend the GSCB multi-agency training programme, which takes place during the daytime and on weekdays. In 2018-2019, we trained 60 workers involving five groups. We also continued to promote access to online training on safeguarding.

What was the impact?
Groups gave positive feedback on the mental health workshop with almost all the 40 groups participating strongly agreeing that they had increased their understanding of the topic. They also strongly agreed that they knew where to go for further information to provide better support for children and young people with mental health issues.

What we plan to do next?
METRO GAVS will continue to promote the GSCB training schedule and other courses including those provided on online to local organisations.

We will also continue to provide evening and weekend safeguarding training for groups unable to attend GSCB courses.

We will use the safer organisation toolkit to carry out a single agency audit on the effectiveness of safeguarding in the voluntary sector.

Example of effective practice
In 2018-2019, METRO GAVS used the Mental Health Deep Dive report to help 4 groups to access funding for early intervention work with children and young people with low level mental health issues.
Royal Borough of Greenwich Housing Services

GSCB Executive Board Member: Jamie Carswell, Director of Housing Services

What did we do?
We provided good quality, well maintained homes for our tenants and managed the Housing Register by allocating social housing to those in need, including vulnerable families.

We provided advice, support and statutory assessment services for households at risk of homelessness, which includes families and young people.

The Licensing Scheme for Houses in Multiple Occupation Scheme (HMO) was launched in October 2017. By working with landlords, the Council will drive up standards across the borough’s HMO properties.

How have we made a difference to children?
Young People at Risk of Homelessness
The Housing Service has an excellent track record in the prevention of homelessness for young people through the provision of advice and casework support. Despite often unaffordable rent levels, high eviction rates from private rented accommodation and the impact of welfare reforms, by working in partnership with other services and agencies, and focusing on prevention through the provision of specialist advice and support, the Housing Service has:

- Prevented 1,092 households from becoming homeless in 2018-2019.
- Ensured that families with children did not stay in shared temporary accommodation for lengthy periods of time (the average stay was 11 weeks in 2018-2019)

Appropriate Housing and Support for Families and Young People
The Housing Service provides support and rehousing to families and young people in housing need. Notwithstanding increasing demand, illustrated by over 19,000 applicants on the Housing Register, we continue to prioritise those families and vulnerable young people that are most in need, so that in 2018-2019:

- 181 families in severe overcrowding were rehoused.
- 324 accepted homeless households were rehoused.
- 98 young people, including care leavers and other vulnerable individuals in supported housing schemes were rehoused into suitable properties.

We remain a key partner in the development and management of integrated services for young people at The Point. At our 1st Base Housing Inclusion Service we work with Children’s Services to complete Housing Act and Children’s Act assessments of young people’s needs. The Point provides and commissions a range of multi-agency services to support young people in crisis and young people presenting as homeless with multiple and complex needs.

Clear pathways and protocols with housing associations and support providers ensure supported housing and floating support services are targeted appropriately to meet needs.

The Housing Service manages a budget of just over £2 million for the commissioning of housing support
services for young people, victims of domestic violence, ex-offenders, rough sleepers and those with substance misuse problems. In commissioning services, we require providers to have robust policies and procedures to address the safeguarding needs of clients. The Housing Service Commissioning Officer carries out regular monitoring and reviews of the services with strict reporting requirements ensuring that providers meet best practice standards for safeguarding.

**Proactive Early Help and Child Protection**
Established service pathways and joint working ensure early help is offered to prevent homelessness and provide support for families, young people and children. Risk assessments are undertaken to ensure the safety of clients and mitigate risks. A Housing Case Review Panel of senior managers considers cases of urgent housing need and determines whether a rehousing priority should be awarded if there are safeguarding concerns or risks associated with violence, including domestic abuse. Additionally, Housing staff participate in the Multi-Agency Safeguarding Hub and the Assistant Director is a member of the MASH Strategy Group.

**Supporting Families affected by the Welfare Reforms**
The Welfare Reform Team works with clients affected by welfare reform. The WRT identifies and contacts families to offer advice and support including options on housing, employment, budgeting and childcare. Council tenants facing benefit reduction due to under occupation have been moved to smaller accommodation through WRT support. During 2018-2019 68 households were rehoused.

The team began working with households in receipt of Universal Credit. Additional resources were diverted to the team in preparation for full roll out which took place in October 2018.

**What have we learned?**
In conjunction with Children’s Services we have reviewed and revised our joint policies and procedures for identifying safeguarding concerns within housing and homelessness, including training our Housing Inclusion and Support Service staff.

Compulsory safeguarding training is provided to all tenancy management staff including estate patrol officers with refresher training on a regular basis.

We previously recognised a need for bespoke Children and Adult safeguarding training for all staff having contact with residents. Training for operative staff such as plumbers and electricians who have regular contact with tenants in their homes was delivered.

The training has been positively received and the feedback from staff is that they now have confidence to recognise and report concerns.

**What do we need to do better?**
We should expand our current partnership work and explore funding opportunities with our voluntary and statutory partners in order to bolster early intervention and prevention to safeguard our clients. Furthermore, we must encourage a learning culture and make time for reflective practice

**Examples of Effective Practice**
Joint working between Housing and Children’s Services provides a seamless transition for families facing homelessness, receiving assessment and support to safeguard their dependents. Every possible measure is taken to help the family find alternative accommodation before homelessness occurs.

Successful partnership working takes place at The Point one-stop-shop for young people, where dedicated housing
advice and support is provided alongside services from Children’s Services and health and community agencies. The team ensure that young people receive comprehensive risk assessments to ensure appropriate housing solutions are found, including returning to their family home.

Creation of a Complex Case Panel for Housing and Social Services to review and progress the rehousing of households with complex needs and a requirement for adapted accommodation has been set up. This will improve joint working between the two services, ensure that information is shared and that the household are kept informed of progress.
Community Safety

GSCB Executive Board Member: Sean McDermid, Assistant Director for Community Safety & Environmental Health

The Greenwich Safer Communities Team works with partners to reduce crime and promote safety in Royal Greenwich. Part of this work includes:

- Collating intelligence about, and commissioning work with young people involved in gang activity and serious youth violence.
- Having oversight of the implementation of the Violence Against Women and Girls (VAWG) and Domestic Violence & Abuse strategies and the development or commissioning of several services and initiatives.
- Co-ordination of the Domestic Violence MARAC (Multi-Agency Risk Assessment Conference) which is a panel that manages high risk domestic violence cases.
- Carrying forward the PREVENT agenda in the Royal Borough which includes work to reduce children and young people’s risk of radicalisation.

What Did We Do?

Gangs and Serious Youth Violence

The Safer Communities Team has a Youth Violence, Vulnerability and Exploitation Project Officer who is able to provide advice and guidance to staff and partner agencies on gang-related issues. This specialist input is intended to ensure appropriate risk assessments and partnership action plans are put in place to safeguard young people from gang related violence and crime. The Project Officer works with Police, schools, YOS and social care staff to map the changing dynamics of the gangs picture in the borough. This is used to inform advice on individual young people and strategic decisions on service development.

The Safer Communities Team has commissioned the St Giles Trust to intervene early with young people who are at risk of becoming involved in gangs and SYV and to provide pathways out of violence and gangs for young people wanting to make a break with the past. A Gangs and Serious Youth Violence Training Programme, developed by the Safer Communities Team in partnership with St Giles Trust and the Metropolitan police, has been delivered to staff during 2018-2019 to improve their knowledge and understanding of gangs in Greenwich borough and highlight the interventions and services that are available.

In the previous year (2018-2019) we have continued to fund Growing Against Violence (GAV) which is a positive life skills schools programme to support early intervention and preventative work to stop young people being involved in criminal and gang activity. Sessions are age specific, delivered across year groups from Year 6 to Year 10 and are offered to all schools in the borough, including the Pupil Referral Units and alternative education providers. Information from gangs mapping is used to target delivery especially to schools evidencing a particular need. One of the St Giles Trust mentors is based one day a week at the Newhaven PRU enabling timely and targeted responses to issues involving pupils based there. Of students who completed and returned feedback forms, the feedback is very positive with the vast majority reporting that they enjoyed the session they received, that they know more about risks and are able to make safer decisions.

A Health and Well-being in Schools Network has been developed in partnership with Children’s Services and Public Health to co-ordinate services commissioned by the three departments to deliver work in RBG schools. The purpose
of the Network is to ensure the best possible outcomes for children and young people, address any barriers that providers may encounter when working with schools, ensure that support for schools from commissioned services is targeted equitably and strategically, ensure that providers are informed of key health messages across all areas of Children and Young People’s health and well-being, and are aware of key data that could influence their work.

Violence Against Women and Girls (VAWG), including Domestic Violence
The Safer Communities Team has improved the safety and well-being of victims/survivors and their children by:

- Commissioning an Independent Domestic Abuse Advocacy service for a period of 4 further years to provide support and guidance to victims of Domestic Abuse and their children.
- Commissioning a police Domestic Violence Intervention Team (DVIT) to reduce DV reoffending rates by targeting high risk couples. They pursue and prosecute the perpetrators, support victims to separate from their partner and to pursue criminal proceedings (funding for this initiative ended in March 2019 but the police have built good practice learned from the project into their core service).
- Commissioning an early intervention helpline managed by Housing for Women. This provided victims with vital information and advice about domestic violence and abuse and the support services available locally. This has been backed up by a locally run website: [http://www.gdva.org.uk/](http://www.gdva.org.uk/)
- Continuing to run a domestic violence campaign that aims to tackle attitudes towards DVA, to improve reporting and to inform those involved in DVA about how to obtain help.

Community Safety has chaired the VAWG Strategic Partnership. It has convened and supported the Multi-Agency Risk Assessment Conference (MARAC) which deals with victims at high risk of harm. The MARAC process prioritises the safeguarding of children and young people and involves Children’s Services Social Care when a MARAC referral is received concerning a family where children are present. The information provided can help assess whether a child or a young person is at risk. MARAC continues to convene fortnightly and has been successful in keeping victims and their children safe. An audit of cases demonstrated that overall victims experienced fewer incidents of domestic abuse following referral to MARAC and the subsequent incidents were less serious in terms of harm.

The Safer Communities Team is responsible for ensuring the Safer Greenwich Partnership meets its statutory responsibility for completing Domestic Homicide Reviews (DHRs) to learn lessons from the deaths. To date the borough has completed two reviews (neither of which involved children in the household) and another has just commenced where Children’s Services will be actively involved, due to a child witnessing the event. The Safer Communities Team ensures that recommendations from the DHRs are implemented.

**PREVENT**
A Home Office funded PREVENT Coordinator is based within the Safer Communities Team. His role is to have oversight of all PREVENT cases and counter-terrorist issues in the borough and to take forward initiatives promoted by the Home Office. He manages a PREVENT Education Officer who leads on supporting the Education sector with training, referrals, project delivery and casework.

Sections 36-41 of the Counter Terrorism & Security Act 2015 set out the duty on Local Authorities and partners to provide support for people vulnerable to being
drawn in to terrorism. The CHANNEL Panel is the multi-agency delivery mechanism that meets this duty and has been running in Greenwich since 2011. The panel is chaired by the Royal Greenwich Safer Communities Manager and co-ordinated by the PREVENT Co-ordinator and seeks to manage the risk to any child, young person or adult for whom sufficient concern around radicalisation, extremism or terrorism has been identified. The role of members of CHANNEL is to develop a support plan or intervention for individuals accepted on to it or to consider alternative provisions such as Health or Social Care.

In addition the Greenwich CHANNEL panel has established a supplementary process that puts in place plans or interventions for individuals who have been referred to the PREVENT Co-ordinator because of professional concerns regarding radicalisation, but where the CHANNEL criteria are not met. This is known as PREVENT Case Management (PCM).

The Safer Communities Team co-ordinates bespoke training sessions for staff. These sessions are available for a variety of audiences including front line professionals and young people.

The Safer Communities Team has delivered a number of projects over the last few years using Home Office funding. From 2016 until April 2019 the Safer Communities Team received Home Office funding to pilot the UK’s first Prevent/Gangs crossover project. Known locally as the Somali Youth Support Project and staffed by experienced caseworkers from St Giles Trust, the project seeks to engage and support Somali youth away from the dangers of gang violence, radicalisation and travel to conflict zones and into employment, education and training. In March 2017 the project was independently reviewed and deemed to be a successful ‘proof of concept’ and something the Home Office would seek to replicate in other Boroughs. Sophie Linden, Deputy Mayor for Policing and Crime, has visited and met with project staff. Other recent projects delivered in the Borough via PREVENT include Parentzone, Since 9/11, Equaliteach and Small Steps.

In 2018 the Safer Communities Team launched Operation PERCEPTOR, a pilot multi-agency project aimed at identifying and engaging ‘Unauthorised Education Providers’. The effectiveness of this project has led to MOPAC and DfE showcasing it as an example of collaborative best practice and sending their officers to shadow our staff on the ground.

What Was the Impact?
In 2018-2019 the GAV programme has delivered its workshops to 3,829 pupils, including 900 primary school pupils and 50 at alternative provision.

The St Giles Trust have worked with a number of young people who are at risk of becoming involved in gangs, and their parents, who have previously avoided engagement with statutory services. St Giles staff have identified and looked for ways to meet the young people’s individual needs. They have also helped parents to understand the gang related issues relevant to their children’s lives.

57% of MARAC cases in 2018-2019 involved a family where children are present. The MARAC has typically provided fuller information about the nature of the domestic abuse than that previously disclosed by families to social workers, enabling more accurate assessment of risk to the child.

St Giles Trust have worked with a number of young people who are at risk of becoming radicalised, helping to introduce
a positive, moderating influence in their lives as well identifying and meeting their individual needs.

During 2018-2019 the PREVENT Education Officer provided 48 training sessions and 1,784 staff were trained with the majority being teachers. In the Education sector the PREVENT Education Officer delivered 32 PREVENT sessions with 3,360 pupils.

**What We Plan to Do Next**

During 2019-2020, Community Safety will:
- Input to the development of a new Gangs and Serious Youth Violence Strategy.
- Continue to deliver the Knife Crime Action Plan in partnership with the Police.
- Support the delivery of a new REducation in Serious youth violence and Exploitation Team (RESET) proof of concept.
- Commission a service to deliver the IRIS project across all GP surgeries in the borough to improve GP responses to Domestic Abuse victims.
- Improve Housing staff’s knowledge and confidence in supporting Domestic Abuse Victims that present as homeless or disclose domestic abuse to Tenancy staff.
- Replicate the success and working model of Operation PERCEPTOR in the third sector, in relation to organisations that may be fundraising or enabling support for terrorism-related conflicts abroad.
Lay Members

GSCB Executive Board Member: Damian Walsh

What did we do?

I am one of three volunteer Lay Members on the Greenwich Safeguarding Children Board and have held the role for a year. We are independent of the various agencies comprising the Board and our role is to represent the community in our capacity as Greenwich Borough residents. I was born and raised in the Borough with my primary and secondary schooling in Eltham after which I attended Woolwich College. I also worked for many years in Plumstead and my experience of both living and working in the area provides me with a unique perspective and means that I am familiar with the different aspects and social challenges across the Borough together with the diversity seen among its residents.

My work brought me in to direct and regular contact with people from all sections of society and a diverse range of backgrounds including children and young people. I have also worked with the Prince’s Trust charity that aims to build the confidence of young people to enable them to find opportunities in education, employment or training. My experience working with this group of young people with the aim of achieving positive outcomes was both challenging and rewarding and provided me with some limited understanding of the obstacles they needed to overcome in order to improve their life chances.

What Was the Impact?

My experience and motivation has allowed me to make a positive contribution in the role of Volunteer Lay Member and provide a voice for the community within the meetings I attend, including the GSCB Executive meeting and this year’s Safeguarding Children from Gangs conference. The importance of ‘professional curiosity’ is often emphasised in the delivery of services for young people and this is very much enhanced by the involvement of Lay Members to provide an element of ‘community curiosity’ to ensure that the needs of our children and young people are at the centre of the GSCP decision-making and allocation of resources.

What We Plan To Do Next

Lay members will continue to play an important part in the new partnership arrangements, supporting with community involvement and representing community interests at the Development, Monitoring and Challenge Partnership.
Essential Information

<table>
<thead>
<tr>
<th>Approval Process:</th>
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<tr>
<td>Final Report received and agreed at GSCB Executive</td>
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<tr>
<td>Final Report received by Children’s Trust Board</td>
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<td>Final Report received by Cabinet</td>
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This publication and other information is available on the Greenwich Safeguarding Children Board Website: [www.greenwichsafeguardingchildren.org.uk](http://www.greenwichsafeguardingchildren.org.uk)

All enquiries regarding the Greenwich Safeguarding Children Board should be made to:
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35 Wellington Street
Woolwich
SE18 6HQ

Phone: 020 8921 4477
Email: safeguardingchildren@royalgreenwich.gov.uk
Website: [www.greenwichsafeguardingchildren.org.uk](http://www.greenwichsafeguardingchildren.org.uk)
Appendix 1 – GSCB Financial Information 2018-2019

The GSCB budget ended 2018-2019 with an overspend position of £13,095. This was due to costs associated with the employment of agency staff. A draw down from the GSCB reserve was made to fund this overspend.

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<td>Other Charges for Services</td>
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Appendix 2 – Agency Attendance at GSCB Executive Meeting 2018-2019

There were 5 meetings in 2018-2019 as an extraordinary meeting was called to consider a serious case review.

(Standard required is 75% attendance)
Appendix 3 – Attendance at GSCB training 2018-2019
Appendix 4 – Overview of the GSCB

Greenwich Safeguarding Children Board

Overview of: Principles, Scope and Functions, Governance, Accountability, Membership and Structure

Introduction
The Greenwich Safeguarding Children Board (GSCB) is the statutory inter-agency mechanism for agreeing how the different services and professional groups should co-operate to safeguard and promote the welfare of all children in Royal Greenwich and to hold each other to account, ensuring that safeguarding children remains high on each partner agency’s agenda (Children Act 2004). The Board has a lead role in monitoring and scrutinising those arrangements to ensure that they work effectively and result in better outcomes for children and driving improvement across the partnership.

Underlying Principles of the GSCB
The GSCB is a child centred partnership that is independent from all organisations. It provides system wide leadership and has responsibility for the scrutiny and challenge of safeguarding practices throughout agencies in the Royal Borough of Greenwich. The interests of children and young people and their journey throughout services will be central to the work and strategic decisions made by the Board. Throughout the work of the Board, the emphasis is on facilitating continuous learning with the aim of constantly improving practice so that children, young people and families are receiving effective services and support as early as possible.

Arrangements for an effective GSCB
The effectiveness of the GSCB is characterised by:

- A clear commitment by all agencies to co-operate with each other and actively work to safeguard and promote the welfare of children.
- Effective system wide leadership with senior managers in all agencies committed to the importance of safeguarding and promoting children’s welfare.
- Clear lines of accountability.
- Clear and effective communication links within the GSCB network and the wider strategic network.
- A risk based approach, whereby the GSCB has oversight of risk factors and controls across the partnership, as well as in individual agencies, and holds partners to account for minimising risk.
- A professional culture of openness to challenge about agencies safeguarding arrangements.
- A shared ‘learning culture’.
- A commitment to partnership funding that adequately resources the work of the Board.
- An agreed structure of work groups that enable the annual work plan to be progressed.

Scope of the GSCB’s Role
The GSCB maintains strategic overview of how organisations work with children, young people and families to provide early help and safeguarding intervention when necessary. Board members in consultation with their agencies and organisations set and review strategic priorities, which are set out in an Annual Business Plan, thus driving the focus of safeguarding work throughout the Royal Borough.

Functions of the GSCB
Statutory guidance sets out the functions of the GSCB which include:
1. Develop local policies and procedures for how the different organisations will work together on safeguarding and promoting the welfare of children including those on:
   - action taken where there are concerns about the safety and welfare of a child, including thresholds for intervention
   - training of people who are in contact with children or their families
   - recruitment and supervision of people who work with children
   - investigation of allegations concerning people who work with children
   - safety and welfare of children who are privately fostered
   - co-operation with neighbouring children’s services authorities (i.e. local authorities) and their LSCB partners.

2. Communicate the need to safeguard and promote the welfare of children and participate in local planning.

3. Undertake a Serious Case Review where abuse or neglect of a child is known or suspected, a child has died, or been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

4. Review the deaths of all children who are normally resident in their area and put in place procedures to ensure that there is a co-ordinated response by relevant organisations to an unexpected death of a child.

5. Monitor and evaluate the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve. This should include as a minimum:
   - assessing the effectiveness and impact of the help being provided to children and families, including early help
   - quality assuring practice, for example through joint audits of case files involving practitioners and identifying lessons to be learned.

6. Assess whether Board partners are fulfilling their statutory obligations under Section 11 of the Children Act 2004 and parallel duties and asking Board partners to self-evaluate.

7. Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

8. Produce and publish an annual report on the effectiveness of safeguarding and promoting the welfare of children in the local area. The purpose of this report is to ask whether safeguarding arrangements are working, and if not, why not. It should provide local partners and the public with a rigorous and transparent assessment of the performance of local services. Once published the annual report should be submitted to the Chief Executive and Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Well-being Board.

How does the GSCB hold partners to account?

The GSCB does not commission or deliver services. Each Board partner retains their own existing line of accountability for safeguarding. While the GSCB does not have the power to direct other organisations, the GSCB is committed to making it clear where improvement is needed.

The GSCB holds organisations to account through Serious Case Reviews, multi-agency case audits, reports to the GSCB, 1:1 meetings with the Chair, Section 11 reports and review of the local multi-agency performance framework. Areas requiring improvement and action needed to address risk will be formally agreed and reviewed at the GSCB Executive Partnership Meetings. In order to support multi-agency engagement, the GSCB Chairs group monitors attendance and partners’
contribution to GSCB Work Groups and training. Any difficulties will be reported to the GSCB Executive Partnership Board.

**Governance Arrangements**

Greenwich Safeguarding Children Board links with Strategic Bodies, the Children and Young People Plan and the Joint Strategic Needs Assessment

The work of the GSCB will sit within the wider context of the Children's Trust arrangements to improve outcomes for all children.

GSCB will link with the strategic partnerships working in the locality which includes the following:

- Children’s Services Strategic Partnership
- Children’s Trust Board
- Safer Greenwich Partnership (Youth Crime JCG, Alcohol and Substance Misuse JCG and Violence against Women and Girls Partnership (including MARAC))
- Multi-Agency Public Protection Arrangements (MAPPA – a statutory operational arrangement led by police and probation)
- Health and Well-being Board
- Safeguarding Adults Board

The GSCB will contribute to and be consulted on the development of the Children and Young People Plan. The work plan of the GSCB will reflect the safeguarding priorities of the Children’s Plan. Similarly, the GSCB will both inform and draw on the Joint Strategic Needs Assessment (JSNA) and Health and Well-Being Strategy.

**Membership of the Greenwich Safeguarding Children Board Executive Partnership Board**

The Greenwich Safeguarding Children Board Executive Partnership consists of senior representatives from its member agencies as required by legislation.

This includes:

- GSCB Independent Chair
- RBG Children’s Services – Director of Children’s Services
- Lewisham and Greenwich NHS Trust – Divisional General Manager, Children's Services
- Oxleas – Service Director of Children & YP Service
- GCCG – Director of Integrated Governance
- CAIT – Detective Inspector
- Borough Police – Detective Chief Inspector, Plumstead Police Station
- Probation
- Adult Services – Senior Assistant Director
- Voluntary Sector – GAVS Development Officer
- Lay Members
- Community Housing Services – Head of Community Services
- Community Safety – Head of Community Safety
- Youth Offending Services – Head of Service
- Head Teacher
- Lead Member for Children’s Services (Participant Observer)
- CAFCASS
- GSCB Manager

It is acknowledged that in order for GSCB to retain its strategic focus and be effective in its role the Board membership will be limited. However GSCB recognise that the network working with or in contact with children and their families in Royal Greenwich is vast and that engagement with the wider network will occur via the GSCB MAC Group, GSCB Work Groups and steering groups, representation on thematic groups and other Strategic Partnerships as well as through training sessions, the GSCB Annual Conference and via communication and publicity campaigns.
Chair of the Greenwich Safeguarding Children Board

In order to enable the GSCB to exercise its local challenge function effectively, the Chair of the GSCB is independent of local agencies and is appointed or removed following consultation with Board partners. The Chair supports the Board to operate with an independent voice and ensure that the Board is not subordinate to, nor subsumed within other local structures in a way that compromises it.

Accountability

The Director of Children’s Services will be held accountable for the effective working of the GSCB by the Chief Executive and challenged where appropriate by the Lead Member.

Elected Members

The Lead Member for Children’s Services will have a particular focus on how the Council discharges its responsibilities in relation to safeguarding and promoting the welfare of children. The lead member will attend GSCB Executive meetings as a ‘participant observer’.

Board Members

A ‘Job Description’ for members is provided.

In order for Board Members to be effective in their role, it is the expectation that all Board members will have the authority to:

- Be accountable to the Board on behalf of their organisation/agency.
- Ensure arrangements for safeguarding and promoting the welfare of children are working effectively to bring about good outcomes for children, in accordance with S11 Children Act 2004 and statutory guidance.
- Commit resources of their organisation to a policy or course of action.
- Agree their organisation’s contribution to the Board’s annual budget.
- Ensure commitment of staff and resources to ensure the effective function of the Board.
- Implement changes to practice within their own organisation/agency.
- Ensure effective response to strategic and policy recommendations within their own organisation.
- Contribute to and work within the framework established by the Greenwich Children and Young People Plan.

Structure of the GSCB

The **GSCB Executive Partnership Board** holds a strategic overview of safeguarding activity across the Royal Borough. It is responsible for:

1. Independent monitoring, scrutiny, challenge and problem solving.
2. Focusing on the impact and outcomes of Board activity to children and families.
4. Holding partners to account through Quality Assurance Activity.
5. Agreeing and reviewing strategic priorities.
6. Monitoring implementation and effectiveness of local response to national policy and priorities.
7. Communicating messages to the network via its partners and Work Groups.
8. Ensuring that the Board maintains focus on on-going learning and development.

The GSCB Executive Partnership will meet a minimum of 4 times per year. The GSCB Independent Chair will call an extraordinary meeting should a particular need arise.

The **GSCB Chairs group** is the forum whereby the Work Group Chairs will:

1. Monitor GSCB Business Plan including Work Groups.
2. Receive reports, undertake analysis, monitor action plans and approve work
completed by the Work Groups, GSCB staff and/or others on behalf of the GSCB.

3. Undertake scrutiny and challenge through the regular review of the Strategic Priorities Register.

4. Identify and address cross-cutting themes including:
   - Capacity
   - Ownership
   - Engaging children, young people and families
   - Diversity
   - Forward Planning
   - GSCB priorities

5. Identify development needs for the effective functioning of the LSCB.

6. Set the Agenda for the GSCB Executive Partnership.

GSCB Work Groups are chaired by Senior Professionals from the multi-agency partnership. Their role is to progress the work plan of the board, with an emphasis on the strategic priorities. They will report into the Chairs Group on a rolling basis. A report on the activity of the Work Groups will be presented to the Executive Partnership at least annually.

The GSCB work groups consist of:
- Serious Case Review
- CSE MASE
- Child Death Overview Panel
- Learning and Development
- Audit
- Communication and Engagement
- Toxic Trio
- Health
- Missing
- Schools
- Monitoring and Challenge

Professional Support to the GSCB

In order to meet the demands of the work plan the GSCB has a Board Manager and a Learning and Improvement Co-ordinator who oversee the Annual Business Plan. These staff members support Board Members and Work Group Chairs to progress the day-to-day work of the Board.
Appendix 5 - GSCB Structure Chart
Appendix 6 - Glossary

CAIT – Child Abuse Investigation Team
CiCC – Children in Care Council
CiN – Child in Need
CPP – Child Protection Plan
CRC – Community Rehabilitation Company (Probation)
CSE – Child Sexual Exploitation
DHAS – Department of Health and Adult Services
DV – Domestic Violence
EHA – Early Help Assessment
GCCG – Greenwich Clinical Commissioning Group
GSCB – Greenwich Safeguarding Children Board
LAC – Looked After Child
LADO – Local Authority Designated Officer
LGT – Lewisham and Greenwich NHS Trust
MAPPA – Multi-Agency Public Protection Arrangements
MARAC – Multi-Agency Risk Assessment Conference
MASH – Multi-Agency Safeguarding Hub
NPS – National Probation Service
QEH – Queen Elizabeth Hospital
SCR – Serious Case Review
SENCO – Special Educational Needs Co-ordinator
TAC – Team around the Child
TF – Troubled Families programme
TRILOGY PLUS – Police unit who have replaced VOCU
UHL – University Hospital Lewisham
VAWG – Violence Against Women and Girls
VOCU – The Violent and Organised Crime Unit
YOS – Youth Offending Services
For more information on the work of the Greenwich Safeguarding Children Partnership visit:
www.greenwichsafeguardingchildren.org.uk